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Advance Directives for Older Adults in Primary Care: An Intervention to Promote Screening and Documentation

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Kathryn Bower, Student

Dr. Elizabeth Tovar, Advisor

Advance Directives for Older Adults in Primary Care:

An Intervention to Promote Screening and Documentation

Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Nursing Practice at the University of Kentucky

By

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Abstract

Background: Advance care planning is the process of making decisions about the healthcare one wishes to receive should they become unable to make decisions for themselves, including the development of advance directives and designation of health care surrogates. Advance care planning is universally supported by governing bodies and professional organizations; however, less than one-third of Americans have an advance directive or designated health care surrogate. Purpose: The purpose of this project was to assess primary care provider attitudes and knowledge of advance care planning and to increase screening for and documentation of advance directives and/or health care surrogates in patients age 65 years and older in a primary care setting.

Methods: This study was a quasi-experimental one group pre-test posttest design to assess the effect of provider education on provider screening and documentation rates of advance directives and/or health care surrogates in patients age 65 years and older in the primary care setting. Provider attitudes and knowledge of advance care planning were assessed through an attitudes survey and knowledge questionnaire.

Results: Pre-intervention screening, or documentation of either a negative or affirmative response to having an advance directive, was relatively high (79.9%). Documentation, or scanning an advance directive, including living will or power of attorney, into the media portion of the electronic medical record or documentation of the name of a designated health care surrogate in the electronic medical record, was low (3.9%). Although improvements in screening (84.5%) and documentation (5.6%) were seen post intervention, they were not statistically significant ($p=0.41$; $p=0.56$). Providers reported an overall positive attitude toward advance care planning as well as a lack of training and confidence in advance care planning. Provider knowledge of advance care planning improved from pre-intervention (70.5%) to post

intervention (83.8%), although the improvement was not statistically significant (p=0.3). Providers identified inclusion in work flow, patient initiation of the topic, having available resources, and organizational support to be facilitators of advance care planning, and lack of provider comfort with the topic, inadequate time for discussion, lack of available resources, and lack of interest from the patient to be barriers to advance care planning.

Conclusion: This study successfully assessed provider attitudes and knowledge of advance care planning, identified specific facilitators and barriers to the process, and identified a high screening rate for advance directives in patients age 65 years and older. The study also highlighted the severe deficiency in documentation of advance directives and health care surrogates in the electronic medical record despite relatively high screening rates. Continued efforts should be made to ensure our primary care patients have their wishes documented in their record in order to improve quality and satisfaction with end-of-life care, decrease unnecessary hospitalizations and interventions at the end-of-life, and decrease cost to the health care system.

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Dedication

To my husband Jeremy, who without his support and patience, this would not have been possible, and to my daughter Hannah, for sharing mommy with this adventure. I love you both more than words and hope I've made you proud.

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Advance Directives for Older Adults in Primary Care: An Intervention to Promote Screening and Documentation

Background

The number of individuals aged 65 years and older is dramatically increasing, medical interventions are rapidly advancing, and cost of health care is on the rise, making it ever more important for providers to have end-of-life discussions with their patients. Advance care planning is a crucial part of those discussions. Sudore et al. (2017) define advance care planning as

> a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding their future medical care. The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness. (p. 821)

Advance care planning, including the development of advance directives and designation of health care surrogates, is universally supported by governing bodies and professional organizations. However, less than one-third of Americans have an advance directive or designated health care surrogate (U.S. Department of Health and Human Services [HHS], 2008; Yadav et al., 2017). Most individuals would prefer to die at home, while having their symptoms managed and comfort prioritized, yet estimates indicate that of the 18 to 37 percent of adults who have an advance directive and/or health care surrogate, less than one-third of these are known to providers (HHS, 2008; Yadav et al., 2017). Failure to participate in advance care planning often results in end-of life care that is incongruent with patients' wishes, including unnecessary hospitalizations and unwanted interventions, increased pain and suffering, and increased cost to

families and the healthcare system (Bischoff, Sudore, Miao, Boscardin, & Smith, 2013; HHS, 2008; Institute of Medicine [IOM], 2014).

Review of Literature

According to the literature, inadequate advance care planning, including screening for and documentation of advance directives and/or health care surrogates in primary care, is the result of patient and provider related barriers. Providers cite discomfort with end-of-life discussions, inadequate time for appropriate discussion, and lack of reimbursement and institutional support as barriers to advance care planning (Spoelhof & Elliott, 2012). Patient barriers include fear, poor health literacy, lack of interest or knowledge, isolation, and cultural traditions (Spoelhof & Elliott, 2012). Since both providers and patients are hesitant to discuss death and dying and each tends to wait for the other to initiate the discussion it is important to create interventions to increase provider confidence and competence regarding advance care planning are important. (IOM, 2014; Spoelhof & Elliott, 2012),

The promotion of advance care planning within the primary care setting involves both provider and patient focused interventions. Strategies should take into account that providers must be both confident and competent in their ability to facilitate end of life discussions, aid in creating advance directives, and provide guidance in selecting a health care surrogate. Multimodal interventions, including provider education and reminders, have been shown to be effective in improving the screening and documentation of advance directives (Durbin, Fish, Bachman, & Smith, 2010; Ramsaroop, Reid, & Adelman, 2007). The promotion of advance care planning in the primary care setting can improve quality of care at the end of life, reducing unnecessary pain and suffering associated with hospitalization and interventions, and decreasing burden for families and the healthcare system.

Purpose

The purpose of this project was to assess provider attitudes and knowledge of advance care planning and to increase screening and documentation rates in the primary care setting. The short-term aims of this project were to assess provider attitudes and knowledge of advance care planning and to increase screening and documentation rates in a primary care setting. The long-term expected outcomes were improved quality and patient satisfaction with end-of-life care, a decrease in unnecessary hospitalizations and interventions at the end-of-life, and a decrease in costs to the health care system.

It was hypothesized that through this project there would be an increase in advance care planning, including screening for and documentation of advance directives and/or health care surrogates in patients aged 65 years and older in the primary care setting. The specific aims were to:

1. Describe the current practices of advance care planning in a single primary care setting.
2. Assess provider attitudes and knowledge, perceived barriers, and facilitators of advance care planning.
3. Examine the effect of provider education on screening for and documentation of advance directives and/or health care surrogates in patients ages 65 years and older in a primary care setting.

Methods

Design

This study was a quasi-experimental one group pre-test posttest design to assess provider attitudes about advance care planning and the effect of provider education on screening for and

documentation of advance directives and/or health care surrogates in patients aged 65 years and older in the primary care setting. A retrospective chart review provided baseline screening and documentation rates for three months prior to the intervention. A retrospective chart review was then performed to obtain screening and documentation rates for six weeks post intervention.

Charts reviewed were those of primary care patients aged 65 years or older presenting for a routine medical exam. Charts for patients under the age of 65 years old and patients presenting for acute or episodic visits were excluded from review. A total of 168 charts were reviewed to obtain pre-intervention data and 137 charts were reviewed to obtain post intervention data.

Sample

There were two study populations, patients and providers. For the retrospective chart review, the population included all patients age 65 years and older who presented to the designated primary care office for a routine medical exam (ICD 10 code Z00.00) during the study period, three months prior to and six weeks following the intervention. For the attitude and knowledge evaluation and educational intervention, a convenience sample of physician and nurse-practitioner primary care providers in the designated primary care office was used. This sample included both physicians and nurse practitioners, full-time and part-time, whose primary population is adult patients age 18 years of age and older. Specialty and pediatric practitioners were excluded from the sample. Providers were introduced to the study through a brief presentation by the primary investigator at a routine provider meeting. Providers then received an email invitation to participated in the study, which included a description of the study, voluntary consent, and a link to the pre-intervention survey.

Setting

This study was conducted at a single ambulatory care practice in Louisville, Kentucky. The primary care practice, which is part of a larger healthcare organization, serves approximately 12,000 patients annually with over 22,000 total office visits. Approximately 37% of the patient population are age 65 years or older. The practice employs six primary care providers and 19 staff members, both clinical and non-clinical.

Procedures

This study was conducted in three phases. The first phase included a baseline assessment and evaluation of current advance care planning practices. The second phase was the intervention phase. The third phase was an assessment and evaluation of the intervention.

Phase One. This phase consisted of a retrospective chart review and provider survey to describe the current practices of advance care planning in a single primary care office. The review was performed to obtain baseline screening and documentation rates for three months prior to the educational intervention. Charts for patients age 65 years and older seen for a routine office visit (ICD Code z00.00) were reviewed for evidence of screening for advance directives and or/health care surrogates and documentation of advance directives and/or health care surrogates. Patient demographics were obtained including age, gender, race/ethnicity, and medical coverage (see Appendix A).

Primary care physicians and nurse practitioners who chose to participate completed an online survey (see Appendix B) to assess attitudes toward, facilitators of, barriers to, and knowledge of advance care planning. This online survey, developed by the primary investigator, was used to tailor the educational intervention to promote advance care planning within the practice. Provider demographics including age, gender, professional role and number of years in

practice were obtained. This survey was created and administered with Qualtrics online survey platform.

Phase Two. The primary investigator developed a brief educational intervention on advance care planning, and screening for and documentation of advance directives and/or health care surrogates. The intervention consisted of a presentation (see Appendix C) on advance care planning, including instruction on screening for and documentation of advance directives and/or health care surrogates. Providers were given the option to complete the education in a one to one, small group, or online session. Providers and staff were also given a resource folder (see Appendix D) that included a reference sheet and resources for providers and patients on advance care planning.

Phase Three. This phase consisted of a provider survey and retrospective chart review. Immediately following the intervention, participating providers completed an online survey to assess changes in knowledge of advance care planning and evaluate the educational intervention. This survey was also created by the primary investigator and administered with Qualtrics online survey platform.

The chart review assessed the post-intervention screening and documentation practices for advance directives and/or health care surrogates for six weeks post intervention. Charts were audited for evidence of screening for advance directives and/or healthcare surrogates and documentation of advance directives and/or health care surrogates. Patient demographics were obtained including age, gender, race/ethnicity, and medical coverage (see Appendix A).

Theoretical Framework

This study was guided by the adult learning theory developed by Malcolm Knowles. (Knowles, 1980) Knowles named his theory andragogy, or “the art and science of helping adults

learn" (Knowles, 1980, p. 43). The theory is grounded on four assumptions about adult learners. First, adult learners are self-directed in the planning, participation, and evaluation of learning. Second, adult learners bring personal experiences which serve as a resource for their learning. Third, adult learners' readiness to learn is based on what is relevant and useful to specific tasks or roles. Finally, adult learners are problem solving and performance-centered, focusing on knowledge which can be applied immediately. (Knowles, 1978; Knowles, 1980)

This framework was applied to the study by surveying providers about their attitudes and knowledge of advance care planning prior to the development of the educational intervention. This allowed the primary investigator to evaluate the providers receptiveness to the education and tailor the educational intervention to their needs. Providers were also allowed to choose the method of presentation of the educational intervention and asked to evaluate the intervention at completion. The educational intervention was focused on providing information that would be relevant and useful to providers in their everyday practice.

Data Collection

Data collection for this study included retrospective chart reviews and provider surveys. Approval from Norton Healthcare and the University of Kentucky's Institutional Review Board were obtained prior to requesting medical records for review or soliciting provider participation.

Measures

Aim 1. Describe the current practices of advance care planning in a single primary care setting. In order to describe the current practices of advance care planning in a single primary care setting, a retrospective chart review was conducted to assess screening and documentation rates. Documentation of either a negative or affirmative response to having an advance directive in patient demographics, provider note, or visit diagnoses, was considered

screened. Lack of documentation on advance directives was considered not screened. Scanning an advance directive, including living will or power of attorney, into the media portion of the electronic medical record or documentation of the name of a designated health care surrogate in the electronic medical record was considered documented. Absence of these pieces of information was considered not documented.

Aim 2. Assess provider attitudes and knowledge, perceived barriers, and facilitators of advance care planning. In order to assess provider attitudes and knowledge, perceived barriers, and facilitators of advance care planning, a survey (see Appendix B) was used to measure provider attitudes and knowledge of advance care planning. The attitudes portion of the survey consisted of rating Likert scale statements from strongly disagree to strongly agree. A response of agree or strongly agree to a positive statement was considered a positive response. A response of disagree or strongly disagree to a negative statement was also considered a positive response. A response of neither agree nor disagree was considered a negative response in either case. A majority of positive responses was considered an overall positive attitude toward advance care planning.

To identify facilitators and barriers of advance care planning, providers were asked to select facilitators of advance care planning and barriers to advance care planning from a provided list of facilitators and barriers identified through the literature review. They were also provided space to write in perceived facilitators and barriers not listed.

The survey also included knowledge based true or false and multiple-choice questions to evaluate their knowledge of advance care planning, screening, and documentation. The results of this portion of the survey will be reported as percentage correct and average provider scores.

Aim 3. Examine the effect of provider education on screening for and documentation of advance directives and/or health care surrogates for patients of ages 65 years and older in the primary care setting. Documentation of either a negative or affirmative response to having an advance directive in patient demographics, provider note, or visit diagnoses, was considered screened. Lack of documentation on advance directives was considered not screened. Scanning an advance directive, including living will or power of attorney, into the media portion of the electronic medical record or documentation of the name of a designated health care surrogate in the electronic medical record was considered documented. Absence of these pieces of information was considered not documented. Post intervention screening and documentation rates were compared to pre-intervention rates to determine if there was a significant change in screening and documentation rates.

A post-intervention survey (see Appendix E) reassessed provider knowledge with true or false and multiple-choice questions. Results of this portion were reported as a percentage correct and average provider score and were compared to pre-intervention scores to determine if there was a significant change in knowledge of advance care planning screening and documentation. Providers were also asked to complete survey questions evaluating the educational session.

Data Analysis

Data analysis was performed using SPSS statistical software under the direction of a professional statistician. Descriptive statistics (frequency, proportion, range, mean, median, and standard deviation) were used to analyze provider attitudes, barriers, and facilitators. Provider attitudes will be reported as a proportion of providers with an overall positive attitude toward advance care planning pre and post intervention. A change in provider knowledge from pre- to

post- intervention surveys was also analyzed using paired t-test. Barriers to and facilitators of advance care planning were reported by frequency and percentage of providers reporting.

Screening and documentation rates for advance directives and/or healthcare surrogates from pre-intervention to post-intervention was analyzed using chi-square analysis. Change was reported in terms of magnitude and statistical significance.

In addition, demographic data were analyzed for both providers and patients. Provider data included provider type, gender, age, and years in practice. Patient data included gender, age, race/ethnicity, type of insurance, and type of visit. These data were analyzed using descriptive statistics. Age and years in practice were reported in a range and average. All other demographic variables were reported according to frequency and percentage

Results

Aim 1. Describe the current practices of advance care planning in a single primary care setting. A retrospective chart review was performed on all charts for patients aged 65 years and older who presented at the designated primary care office during a three-month period prior to the intervention for a routine office visit falling under the Z00.00 ICD-10 code. A total of 168 medical records were provided for review. Of these 14 were excluded because they did not meet one of the study criteria or were a duplicate record, leaving 154 medical records to be analyzed for preintervention data. Demographics including age, gender, race, payor, and provider for each reviewed record are provided in Table 1.

Of the 154 charts that were reviewed, 123 (79.9%) had documentation of either a negative or affirmative response to having an advance directive. Thirty-one (20.1%) of the medical records reviewed had no documentation of screening for advance directives (see Table 2). Of the 123 patients who were screened, 53 (43.1%) said they had an advance directive,

whether it was in their chart or at home, and 21 (17.1%) said they needed an advance directive and were supplied with sample forms (see Table 3).

Of the 154 charts that were reviewed, only six (3.9%) had an advance directive, including a living will or power of attorney, scanned into the media portion of the electronic medical record or the name of a designated health care surrogate documented in the electronic medical record. The remaining 148 (96.1%) had no documentation of advance directives (see Table 2). Of the 53 patients who said they had an advance directive, only two (8.8%) had an advance directive documented in the medical record (see Table 3).

Aim 2. Assess provider attitudes and knowledge, perceived barriers, and facilitators of advance care planning. All primary care providers at the designated primary care practice were invited to participate in the study. Of the six providers in the office, two were excluded as specialty providers, and two chose not to participate in the survey and intervention portions of this study, leaving two (33%) participating providers. The sample included one medical doctor and one nurse practioner, with an average of 16.5 years in practice.

Provider attitudes toward advance care planning were assessed using five Likert scale type questions with responses ranging from strongly disagree (x=1) to strongly agree (x=5; see Figure 1). Providers generally agreed that advance care planning is important for primary care patients aged 65 years and older ($\bar{x}$=5), that it is their responsibility to provide advance care planning to patients aged 65 years and older ($\bar{x}$=4.5), and that they engage in advance care planning with their patients aged 65 years and older ($\bar{x}$=4.5). Conversely, providers did not agree that they had received adequate training through formal education and/or on the job training on advance care planning ($\bar{x}$=3) or that they possessed confidence in their ability to provide advance care planning to primary care patients ($\bar{x}$=2.5).

Provider knowledge of advance care planning was assessed using a six-question test, including true or false and multiple-choice questions. An average score of 70.5% out of 100% (SD = 5.4) was obtained on pre-test knowledge questions (see Table 5).

Providers identified facilitators of advance care planning to be inclusion in work flow (n=2, 100%), patient initiation of the topic (n=1, 50%), having available resources (n=1, 50%), and organizational support (n=1, 100%; see Table 4). Provider identified barriers to advance care planning included lack of provider comfort with the topic (n=2, 100%), inadequate time for discussion (n=2, 100%), lack of available resources (n=2, 100%), and lack of interest from the patient (n=1, 100%).

Aim 3. Examine the effect of provider education on screening for and documentation of advance directives and/or health care surrogates in patients of ages 65 years and older in the primary care setting. A second chart review was performed on all charts for patients aged 65 years and older who presented at the designated primary care office during the six-week period following the intervention for a routine office visit falling under the Z00.00 ICD-10 code. A total of 137 medical records were provided for review. Of these 66 were excluded because they did not meet one of the study criteria or were a duplicate record, leaving 71 medical records to be analyzed for post-intervention data. Demographics including age, gender, race, payor, and provider for each reviewed record are provided in Table 1. There were no significant differences between the pre-intervention patient group and the post-intervention patient group based on age (p=0.30), gender (p=0.62), race (p=0.26), payor (p=0.81), or provider (p=0.44; see Table 1).

Of the 71 charts that were reviewed, 60 (84.5 %) had documentation of either a negative or affirmative response to having an advance directive and 11 (15.1%) of the medical records reviewed had no documentation of screening for advance directives (see Table 2). There was

found to be a 4.6% improvement in screening for advance directives. This improvement was not statistically significant (p=0.41). Further, of the 60 patients who were screened, 26 (43.3%) said they had an advance directive, whether it was in their chart or at home, and 16 (26.7%) said they needed an advance directive and were supplied with sample forms (see Table 3).

Of the 71 charts that were reviewed, four (5.6%) had an advance directive, including a living will or power of attorney, scanned into the media portion of the electronic medical record or the name of a designated health care surrogate documented in the electronic medical record. The remaining 67 (94.4%) had no documentation of advance directives (see Table 2). The 1.7% improvement in documentation of advance directives or health care surrogates was also not statistically significant (p=0.56). Of the 26 patients who said they had an advance directive, only one (4.3%) had an advance directive documented in the medical record (see Table 3).

In addition to analyzing the change in screening and documentation for the entire practice, the study also looked for a change in the screening and documentation rates of the participating providers. For participating providers, screening went from 76.2% pre-intervention to 74.1% post-intervention and documentation increased from 2.4% pre-intervention to 3.7% post intervention. Neither of these changes were statistically significant (p= 0.84, p=0.33).

Provider knowledge of advance care planning was reassessed using the six-question test, including true or false and multiple-choice questions. An average score of 83.8% (SD = 15.6) was obtained on post-test knowledge questions. This increase in score of 13.3% from preintervention scores was not statistically significant (p=0.3; see Table 5).

Finally, providers were asked to evaluate the quality of the educational intervention. In general, providers agreed that the education was presented in a manner that was appropriate for

the content, that they will use the knowledge gained from the educational intervention, and that the educational intervention improved their confidence in advance care planning (see Figure 2).

Discussion

This study was designed to assess provider attitudes and knowledge of advance care planning, identify facilitators and barriers of advance care planning, and improve screening for and documentation of advance directives and health care surrogates in the primary care setting. Providers were found to have an overall positive attitude toward advance care planning but were lacking in their formal education or training and confidence in advance care planning.

Although improvements in screening for and documentation of advance care planning and provider knowledge were not statistically significant, they were improvements nonetheless. Screening rates were highest among Medicare patients, likely because the screening question is included in the *Medicare Annual Wellness Visit* template in the electronic medical record. By adding the screening question to the *Adult Annual Wellness Visit* template in the electronic medical record, screening rates for privately insured patients could be improved significantly. The Institute of Medicine (2014) recommends using the electronic medical record to facilitate documentation and communication of patients wishes. Additionally, electronic medical records can be used to generate patient reminders via electronic messaging and provider reminders to initiate advance care planning discussions and document or review advance directives and health care surrogates. (IOM, 2014; Tieu et al., 2017) Creating standard workflows and a designated documentation location in the electronic medical record is also shown to improve documentation of advance directives and health care surrogates. (Dillon et al., 2017)

The identification of specific facilitators of and barriers to advance care planning can be used to make further improvements. Providers identified resource availability as both a facilitator

of and barrier to advance care planning. Studies suggest that using established advance care planning models, including clinical decision tools, structured communication, and educational interventions, facilitates advance care planning discussions. (Durbin et al., 2010; Oczkowski, Chung, Harvey, Mbuagbaw, & You, 2016; Tung et al., 2011) Utilization of established programs such as Respecting Choices or Five Wishes guides providers and patients through the advance care planning process and improves completion and documentation of advance directives and designation of health care surrogates. (Durbin et al., 2010; IOM, 2017)

Providers also identified initiation of discussions by the patient as a facilitator and lack of interest by the patient as a barrier to advance care planning. One study suggests that providing information on advance directives and healthcare surrogates, including resource materials and sample directives, to patients ahead of their annual wellness visit allows patients to review the materials and complete directives. (Tung et al., 2011) Patients arrive at their wellness visit prepared to hold advance care planning discussions, and the limited visit time can be spent answering specific questions and clarifying patient wishes. (Tung et al., 2011) Development of resource materials that are engaging and meaningful may also encourage patient interest in advance care planning. (IOM, 2014; Jimenez et al., 2018)

Finally, providers cited lack of comfort as a barrier to advance care planning. Providers felt they had not received adequate formal education or on the job training on advance care planning and were not confident in their ability to provide advance care planning to primary care patients. In addition to improving formal education on end of life care and communication practice, studies recommend providing continuing education opportunities and promoting certifications, to increase provider competence in advance care planning. (IOM, 2014) A second study encourages using peer sessions to practice the completion of advance directives and using

scenarios and simulation to prepare providers for advance care planning activities. (Solis, Mancera, & Shen, 2018) By ensuring providers have the knowledge and skills necessary to engage in advance care planning, both confidence and competence improve.

Limitations

Limitations of the study included a lack of access to providers and staff, poor provider participation, and a limited timeframe for post-intervention chart review. Providers and staff run on a tight patient schedule with a focus on productivity, leaving little room for additional face-to-face meetings. Further, a regular staff meeting scheduled during the study time frame was cancelled, leaving communication with office staff to occur through e-mail and office management. Provider participation in the study was low at two of four eligible providers. In addition, the participating providers only saw 27% of pre intervention routine office visits and 38% post intervention routine office visits during the study period. A greater impact on screening and documentation rates may have been possible by reaching the providers who see a greater portion of the wellness visits. Finally, the six-week post-intervention review period was half the time frame of the three-month pre-intervention period, leaving less time for patients to return completed directives to be scanned into the medical record.

While this study provided an assessment of advance care planning practices in a single primary care office, with focus on two providers, additional assessment of other offices in the large health care system and the attitudes and knowledge of other providers and staff would be helpful in promoting advance care planning. Further, directing attention toward including advance care planning in regular workflow and documentation templates, allowing for time for advance care planning during wellness visits, and providing appropriate advance care planning resources to providers and patients could further improve advance care planning activities.

Practice Implications

In an effort to continue to improve advance care planning, including screening for and documentation of advance directives and health care surrogates, this practice should further incorporate screening for advance directives into established work flow. This includes designating the receptionist, medical assistant, or provider to screen for advance directives and/or health care surrogates in patients presenting for a routine office visit or integrating screening for advance directives into the visit documentation template.

Focus should be placed on documentation of advance directives and health care surrogates in the electronic medical record in a designated location, to ensure patient's wishes are clearly stated and easily accessible for health care providers. For patients who state they have an advance directive or designated health care surrogate, appropriate documentation in the designated location in the electronic medical record should be verified and directives should be reviewed for accuracy or changes in preferences. For patients who state they will bring an advance directive or state they need an advance directive and are provided sample documents, follow up should be initiated to ensure the documents are returned and placed in the designated location in the electronic medical record.

Finally, providers and staff alike should be educated on the process of advance care planning and the recommended screening and documentation practices. In addition, they should take part in continuing education on advance care planning to improve both competence and confidence. By taking these steps in caring for older primary care patients, providers can ensure that patients wishes are clearly communicated, translating into end of life care that is congruent with the patient's preferences.

Conclusion

While this study successfully assessed provider attitudes and knowledge of advance care planning, identified specific facilitators and barriers to the process, and identified a high screening rate for advance directives in patients age 65 years and older, the study also highlighted the severe deficiency in documentation of advance directives and health care surrogates in the electronic medical record despite relatively high screening rates. Continued efforts should be made to ensure our primary care patients have their wishes documented in their record in order to improve quality and satisfaction with end-of-life care, decrease unnecessary hospitalizations and interventions at the end-of-life, and decrease cost to the health care system.

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Appendix A

Chart Audit Tool

Patient Identifier	Provider Identifier	Age	Gender	Race/ Ethnicity	Payor	Type of Visit	Is documentation of screening for advance directive/heath care surrogate present?	Is documentation of advance directive/health care surrogate present?
1	A	65	M					

Appendix B

Advance Care Planning – Knowledge and Attitudes, Facilitators and Barriers Survey

Demographics

Q1 Name _____

Q2 Age _____

Q3 Gender

- Male
- Female

Q4 Professional Role

- MD
- PA
- APRN
- RN
- MA
- Other _____

Q5 Years in practice_____

Attitudes

Q6 Advance Care Planning is important for primary care patients age 65 years and older.

- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

Q7 It is my responsibility to provide advance care planning to patients age 65 years and older.

- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

Q8 I have recieved adequate training through formal education and/or on the job training in advance care planning.

- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

Q9 I am confident in my ability to provide advance care planning to primary care patients.

- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

Q10 I engage in advance care planning activities with my patients age 65 years and older.

- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

Facilitators and Barriers

Q11 Facilitators of advance care planning in my practice include (Select all that apply)

- Patient initiation
- Resource availability
- Inclusion in work flow
- Organization support
- Other (please provide comment) _____

Q12 Barriers to advance care planning in my practice include (elect all that apply)

- Lack of comfort
- Inadequate time
- Lack of reimbursement
- Availability of resources
- Other (please provide comment) _____

Knowledge

Q13 Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding their future medical care with the goal of ensuring that people receive medical care that is consistent with their values, goals and preferences.

- True
- False

Q14 Which primary care patients should be screened for an advance directive and/or health care surrogate? (Select all that apply)

- Everyone
- No one
- Patients age 65 years and older
- New patients
- Patients with new chronic diagnosis
- Patients with new terminal diagnosis
- I don't know

Q15 _____ are types of advance directives (Select all that apply)

- Living will
- Medical orders for life sustaining treatment (MOLST)
- Do Not Resuscitate (DNR)
- Organ Donation
- Durable Power of Attorney
- Oral statements
- Health Care Surrogate

Q16 Who should be screened for an advance directive? (Select all that apply)

- No one
- Everyone
- Patients age 65 years and older
- Patients with serious medical conditions
- Patients who are dying
- New patients

Q17 Where can screening for advance directive be documented in the electronic medical record? (Select all that apply)

- Screening should not be documented
- Patient Demographics
- History of Present Illness
- Problems List
- Visit Diagnosis
- Physical Exam
- Review of Systems

Q18 Where should advance directives be documented in the electronic medical record? (Select all that apply)

- Patient Demographics
- Media Tab
- Provider Note
- Paper copy in providers file cabinet
- All of the Above

Appendix C

Resource Folder Contents

University of Kentucky

NORTON HEALTHCARE

Advanced Directives in Primary Care

Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding their future medical care with the goal of ensuring that people receive medical care that is consistent with their values, goals and preferences.

Advance Directives

An advance directive is a written document completed by an adult who can make decisions expressing instructions for future health care in the event they are unable to communicate of loose decision-making abilities.

Living Will Directive/Mental Health Directive
Health Care Surrogate Designation
Medical Orders for Scope of Treatment (MOST)
Power of Attorney

Recommendation

All patients age 65 years and older should have an advance care plan or surrogate decision maker documented in their medical record or documentation that in the medical record that an advance care plan was discussed but the patient did not wish or was unable to name a surrogate decision maker or provide an advance care plan.

Documentation

History of Present Illness (HPI)
Visit Diagnosis
Problems List

Forms

Surrogate Designation and Living Will Directive Form
Medical Orders for Scope of Treatment (MOST) Form

Patient Resources

Advance Directives: You have the right for your wishes to be followed *(Norton Pamphlet)*
Advance Directives *(CareNotes)*

Billing and Coding

CPT 99497: Advance care planning, first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
CPT 99498: Advance care planning, each additional 30 minutes

Follow-Up

Completed Directives should be scanned into electronic medical record and can be located under Patient Demographics or Media (Chart Review).

Advance Directives should be reviewed annually or with changes to patient's overall health or medical conditions.

mln FACT SHEET

PRINT-FRIENDLY VERSION

KNOWLEDGE • RESOURCES • TRAINING

ADVANCE CARE PLANNING

Target Audience: Medicare Fee-For-Service Providers

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

Effective January 1, 2016, the Centers for Medicare & Medicaid Services (CMS) pays for **voluntary** Advance Care Planning (ACP) under the Medicare Physician Fee Schedule (PFS) and the Hospital Outpatient Prospective Payment System (OPPS).

ACP helps Medicare patients make important decisions controlling the type of care they receive and when they receive it. This fact sheet includes:

- Provider and patient eligibility information
- Information on how to code ACP services
- How to bill ACP services
- An example of ACP in practice
- Resources

WHAT IS VOLUNTARY ACP?

Voluntary ACP is a face-to-face service between a physician (or other qualified health care professional) and a patient discussing advance directives with or without completing relevant legal forms. An advance directive is a document in which a patient appoints an agent and/or records the wishes of a patient pertaining to their medical treatment at a future time if they cannot decide for themselves at that time.

PATIENT ELIGIBILITY

Medicare pays for ACP as either:

- A separate Part B medically necessary service
- An optional element of a patient's Annual Wellness Visit (AWV)

When a patient elects to receive ACP services outside of the AWV, we encourage practitioners to notify the patient that Part B cost sharing applies as it does for other physicians' services.

There are no limits on the number of times you can report ACP for a given patient in a given time period. When billing the service multiple times for a given patient, document the change in the patient's health status and/or wishes regarding their end-of-life care.

Some people may need ACP multiple times in a year if they are quite ill and/or their circumstances change. Others may not need the service at all in a year.

PROVIDER AND LOCATION ELIGIBILITY

Physicians and non-physician practitioners (NPPs) may bill ACP services if their scope of practice and Medicare benefit category include the services described by the Current Procedural Terminology (CPT) codes in Table 1. Hospitals may also bill them.

There are no place-of-service limitations on ACP services. You can appropriately furnish ACP services in **facility and non-facility settings**. ACP services are not limited to a particular physician specialty.

DIAGNOSIS

CMS requires no specific diagnosis to bill the ACP codes. Report the condition for which you are counseling the patient using an International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) code to reflect an administrative examination, or a well exam diagnosis when furnished as part of the Medicare AWV.

CODING

Hospitals, physicians, and NPPs should use the CPT codes in Table 1 to file claims for ACP services.

Table 1. CPT Codes and Descriptors

CPT Codes	Billing Code Descriptors
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)

BILLING

Medicare waives the coinsurance and the Medicare Part B deductible for ACP when:

- Provided on the same day as a covered AWV
- Furnished by the same provider as a covered AWV
- Billed with modifier –33 (Preventive Services)

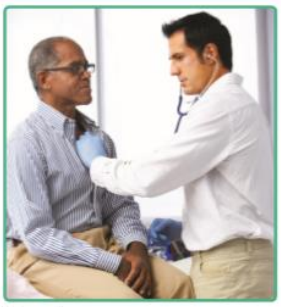
Voluntary ACP is considered a preventive service when billed with the AWV on the same day by the same provider, so CMS waives the deductible and coinsurance for ACP. When AWV is medically necessary and billed with ACP, but the AWV is denied for exceeding the once-per-year limit, payment can still be made for the ACP. In that case, CMS applies the deductible and coinsurance to the ACP service.

The deductible and coinsurance DOES apply when ACP is provided outside the covered AWV.

NOTE: Critical Access Hospitals (CAHs) may bill for ACP using type of bill 85X with revenue codes 96X, 97X, and 98X. The CAH Method II payment is based on the lesser of the actual charge or the facility-specific Medicare PFS.

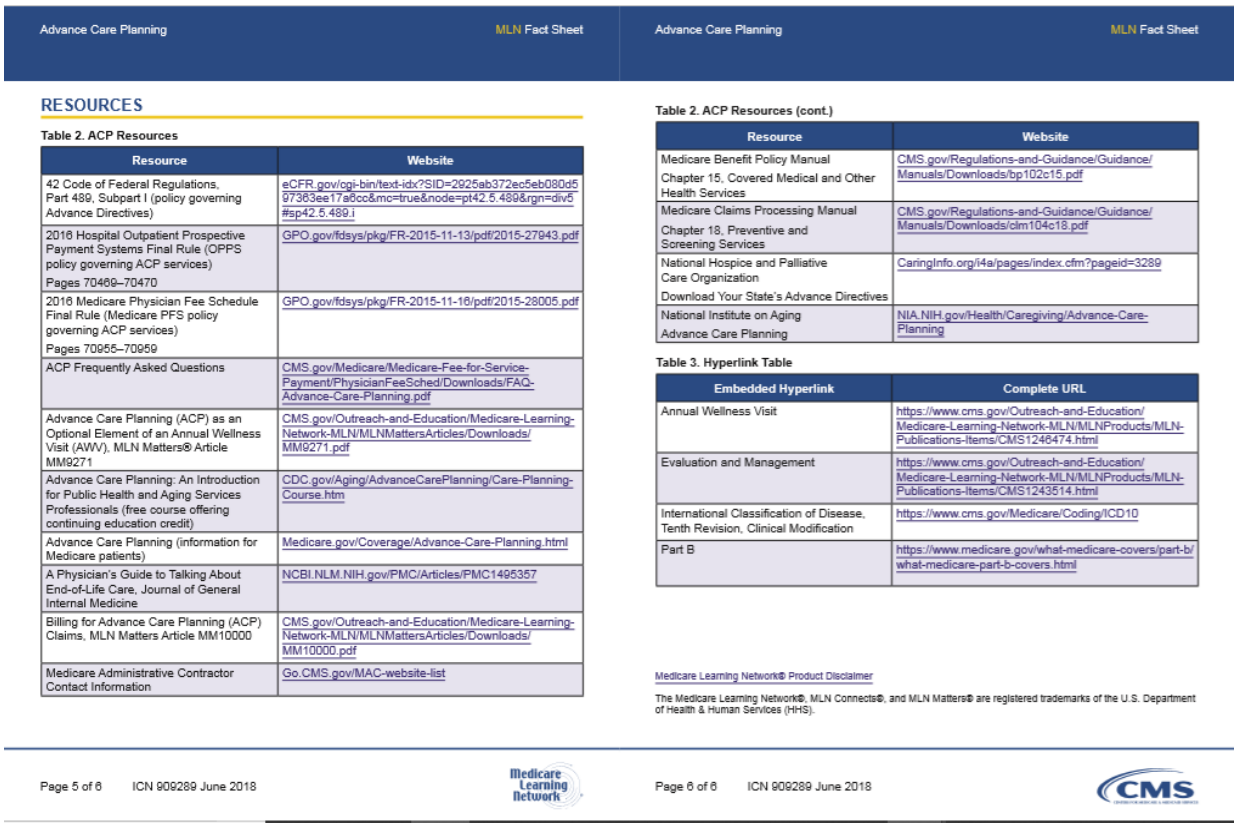
ACP EXAMPLE

A 68-year-old male with heart failure and diabetes is on multiple medications. He is seen by his physician for the Evaluation and Management (E/M) of these two diseases, including adjusting medications as appropriate.



In addition to discussing the patient's short-term treatment options, the patient expresses his interest in discussing long-term treatment options. The doctor and patient talk over the possibility of a heart transplant if his congestive heart failure worsens. They also discuss ACP, including the patient's desire for care and treatment if he suffers a health event that adversely affects his decision-making abilities.

In this case, the physician reports a standard E/M code for the E/M service and one or both of the ACP codes depending on the duration of the ACP service. The ACP service described in this example does not necessarily have to occur on the same day as the E/M service.



RESOURCES

Table 2. ACP Resources

Resource	Website
42 Code of Federal Regulations, Part 489, Subpart I (policy governing Advance Directives)	eCFR.gov/cgi-bin/text-idx?SID=2925ab372ec5eb080d597363ee17a6cc&mc=true&node=pt42.5.489&rgn=div5#sp42.5.489.i
2016 Hospital Outpatient Prospective Payment Systems Final Rule (OPPS policy governing ACP services) Pages 70469–70470	GPO.gov/fdsys/pkg/FR-2015-11-13/pdf/2015-27943.pdf
2016 Medicare Physician Fee Schedule Final Rule (Medicare PFS policy governing ACP services) Pages 70955–70959	GPO.gov/fdsys/pkg/FR-2015-11-16/pdf/2015-28005.pdf
ACP Frequently Asked Questions	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf
Advance Care Planning (ACP) as an Optional Element of an Annual Wellness Visit (AWV), MLN Matters® Article MM9271	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9271.pdf
Advance Care Planning: An Introduction for Public Health and Aging Services Professionals (free course offering continuing education credit)	CDC.gov/Aging/AdvanceCarePlanning/Care-Planning-Course.htm
Advance Care Planning (information for Medicare patients)	Medicare.gov/Coverage/Advance-Care-Planning.html
A Physician's Guide to Talking About End-of-Life Care, Journal of General Internal Medicine	NCBI.NLM.NIH.gov/PMC/Articles/PMC1495357
Billing for Advance Care Planning (ACP) Claims, MLN Matters Article MM10000	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10000.pdf
Medicare Administrative Contractor Contact Information	Go.CMS.gov/MAC-website-list

Table 2. ACP Resources (cont.)

Resource	Website
Medicare Benefit Policy Manual Chapter 15, Covered Medical and Other Health Services	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
Medicare Claims Processing Manual Chapter 18, Preventive and Screening Services	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf
National Hospice and Palliative Care Organization Download Your State's Advance Directives	CaringInfo.org/i4a/pages/index.cfm?pageid=3289
National Institute on Aging Advance Care Planning	NIA.NIH.gov/Health/Caregiving/Advance-Care-Planning

Table 3. Hyperlink Table

Embedded Hyperlink	Complete URL
Annual Wellness Visit	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1246474.html
Evaluation and Management	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243514.html
International Classification of Disease, Tenth Revision, Clinical Modification	https://www.cms.gov/Medicare/Coding/ICD10
Part B	https://www.medicare.gov/what-medicare-covers/part-b/what-medicare-part-b-covers.html

(Centers for Medicare & Medicaid Services [CMS], 2018)

KENTUCKY LIVING WILL PACKET

The Office of the Attorney General
Jack Conway, Attorney General

Living Wills in Kentucky

A Living Will gives you a voice in decisions about your medical care when you are unconscious or too ill to communicate. As long as you are able to express your own decisions, your Living Will will not be used and you can accept or refuse any medical treatment. But if you become seriously ill, you may lose the ability to participate in decisions about your own treatment.

You have the right to make decisions about your health care. No health care may be given to you over your objection, and necessary health care may not be stopped or withheld if you object.

The Kentucky Living Will Directive Act of 1994 was passed to ensure that citizens have the right to make decisions regarding their own medical care, including the right to accept or refuse treatment. This right to decide — to say yes or no to proposed treatment — applies to treatments that extend life, like a breathing machine or a feeding tube.

In Kentucky a Living Will allows you to leave instructions in four critical areas. You can:

- Designate a Health Care Surrogate
- Refuse or request life prolonging treatment
- Refuse or request artificial feeding or hydration (tube feeding)
- Express your wishes regarding organ donation

Everyone age 18 or older can have a Living Will. The effectiveness of a Living Will is suspended during pregnancy.

It is not necessary that you have an attorney draw up your Living Will. Kentucky law (**KRS 311.625**) actually specifies the form you should fill out. You probably should see an attorney if you make changes to the Living Will form. The law also prohibits relatives, heirs, health care providers or guardians from witnessing the Will. You may wish to use a Notary Public in lieu of witnesses.

The Living Will form includes two sections. The first section is the Health Care Surrogate section which allows you to designate one or more persons, such as a family member or close friend, to make health care decisions for you if you lose the ability to decide for yourself. The second section is the Living Will section in which you may make your wishes known regarding life-prolonging treatment so your Health Care Surrogate or Doctor will know what you want them to do. You can also decide whether to donate any of your organs in the event of your death.

When choosing a surrogate, remember that the person you name will have the power to make important treatment decisions, even if other people close to you might urge a different decision. Choose the person best qualified to be your health care surrogate. Also, consider picking a back-up person, in case your first choice isn't available when needed. Be sure to tell the person that you have named them a surrogate and make sure that the person understands what's most important to you. Your wishes should be laid out specifically in the Living Will.

If you decide to make a Living Will, be sure to talk about it with your family and your doctor. The conversation is just as important as the document.

A copy of any Living Will should be put in your medical records. Each time you are admitted for an overnight stay in a hospital or nursing home, you will be asked whether you have a Living Will. You are responsible for telling your hospital or nursing home that you have a Living Will.

If there is anything you do not understand regarding the form, you might want to discuss it with an attorney. You can also ask your doctor to explain the medical issues. When completing the form, you may complete all of the form, or only the parts you want to use. You are not required by law to use these forms. Different forms, written the way you want, may also be used. You should consult with an attorney for advice on drafting your own forms.

You are not required to make a Living Will to receive healthcare or for any other reason. The decision to make a Living Will must be your own personal decision and should only be made after serious consideration.

For additional copies of this packet, you may download it from the Attorney General's website at **ag.ky.gov/livingwill** or make photocopies of this packet.

Instructions for Completing the Kentucky Living Will Form

The Living Will form should be used to let your physician and your family know what kind of life-sustaining treatments you want to receive if you become terminally ill or permanently unconscious and are unable to make your own decisions. This form should also be used if you would like to designate someone to make those healthcare decisions for you should you become unable to express your wishes.

NOTE: You may fill out all or part of the form according to your wishes. Keep in mind that filling out this form is not required for any type of healthcare or any other reason. Filling out this form should solely be a personal decision.

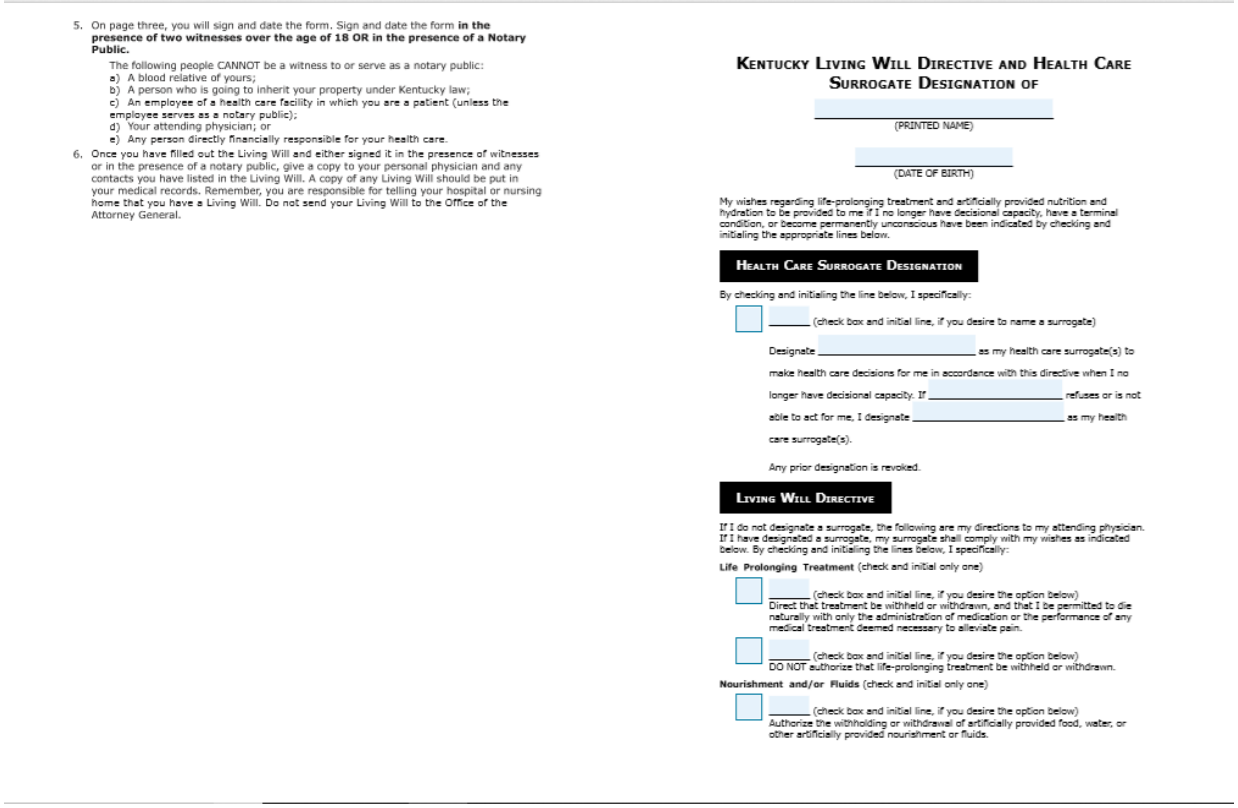
1. Read over all information carefully before filling out any part of the form.
2. At the top of the form in the designated area, print your full name and birth date.
3. The first section of the form on page one relates to designating a "Health Care Surrogate." Fill this section out if you would like to choose someone to make your healthcare decisions for you should you become unable to do so yourself. When choosing a surrogate, remember that the person you name will have the power to make important treatment decisions. Choose the person best qualified to be your health care surrogate. Also, consider picking a back-up person, in case your first choice isn't available when needed. Be sure to tell the person that you have named them a surrogate and make sure that the person understands what's most important to you. **Do not complete this section if you do not wish to name a surrogate.**
4. The next section of the form is the "Living Will Directive." Fill out this section to identify what kinds of life-sustaining treatments you want to receive should you become terminally ill or permanently unconscious.

Life Prolonging Treatment
Under this bolded section on page one, you may designate whether or not you wish to receive treatment (such as a life support machine), and be permitted to die naturally, with only the administration of medication or treatment deemed necessary to alleviate pain. If you do not want treatment, except for pain, and would like to die naturally, check and initial the first line. If you want life-sustaining treatment, check and initial the second line. Check and initial only one line.

Nourishment and/or Fluids
Under this bolded section on page two, you may designate whether or not you wish to receive artificially provided food, water, or other artificially provided nourishment or fluids (such as a feeding tube). If you do not want to receive artificial nourishment or fluids, check and initial the first line. If you want to receive nourishment and/or fluids, check and initial the second line. Check and initial only one line.

Surrogate Determination of Best Interest
Important: This section cannot be completed if you have completed the two previous bolded sections. Under this bolded section on page two, IF you have designated a person as your surrogate in the first section, you may allow that person to make decisions for you regarding life-sustaining treatments and/or nourishment. Check and initial this line ONLY if you wish to allow your surrogate to make decisions for you and if you do not want to detail your specific life-sustaining wishes on this form.

Organ/Tissue Donation
Under this bolded section on page two, you may designate whether or not to donate your all or any part of your body upon your death. If you wish to donate all or part of your body, check and initial the first line. If you do not want to donate all or part of your body, check and initial the second line. Check and initial only one line.



5. On page three, you will sign and date the form. Sign and date the form **in the presence of two witnesses over the age of 18 OR in the presence of a Notary Public.**

   The following people CANNOT be a witness to or serve as a notary public:
   a) A blood relative of yours;
   b) A person who is going to inherit your property under Kentucky law;
   c) An employee of a health care facility in which you are a patient (unless the employee serves as a notary public);
   d) Your attending physician; or
   e) Any person directly financially responsible for your health care.

6. Once you have filled out the Living Will and either signed it in the presence of witnesses or in the presence of a notary public, give a copy to your personal physician and any contacts you have listed in the Living Will. A copy of any Living Will should be put in your medical records. Remember, you are responsible for telling your hospital or nursing home that you have a Living Will. Do not send your Living Will to the Office of the Attorney General.

KENTUCKY LIVING WILL DIRECTIVE AND HEALTH CARE SURROGATE DESIGNATION OF

_____
(PRINTED NAME)

_____
(DATE OF BIRTH)

My wishes regarding life-prolonging treatment and artificially provided nutrition and hydration to be provided to me if I no longer have decisional capacity, have a terminal condition, or become permanently unconscious have been indicated by checking and initialing the appropriate lines below.

HEALTH CARE SURROGATE DESIGNATION

By checking and initialing the line below, I specifically:

☐ _____ (check box and initial line, if you desire to name a surrogate)

Designate _____ as my health care surrogate(s) to make health care decisions for me in accordance with this directive when I no longer have decisional capacity. If _____ refuses or is not able to act for me, I designate _____ as my health care surrogate(s).

Any prior designation is revoked.

LIVING WILL DIRECTIVE

If I do not designate a surrogate, the following are my directions to my attending physician. If I have designated a surrogate, my surrogate shall comply with my wishes as indicated below. By checking and initialing the lines below, I specifically:

Life Prolonging Treatment (check and initial only one)

☐ _____ (check box and initial line, if you desire the option below)
Direct that treatment be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical treatment deemed necessary to alleviate pain.

☐ _____ (check box and initial line, if you desire the option below)
DO NOT authorize that life-prolonging treatment be withheld or withdrawn.

Nourishment and/or Fluids (check and initial only one)

☐ _____ (check box and initial line, if you desire the option below)
Authorize the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids.

LIVING WILL DIRECTIVE — CONTINUED

☐ _____ (check box and initial line, if you desire the option below)
DO NOT authorize the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids.

Surrogate Determination of Best Interest

NOTE: If you desire this option, DO NOT choose any of the preceding options regarding Life Prolonging Treatment and Nourishment and/or Fluids

☐ _____ (check box and initial line, if you desire the option below)
Authorize my surrogate, as designated on the previous page, to withhold or withdraw artificially provided nourishment or fluids, or other treatment if the surrogate determines that withholding or withdrawing is in my best interest; but I do not mandate that withholding or withdrawing.

Organ/Tissue/Eye Donation

I certify that I am eighteen (18) years of age or older and of sound mind, and that upon my death, I hereby give:

Check appropriate boxes and initial the line beside that box:

☐ _____ Any needed organs, tissues, and eye/corneas

OR

The following organs or tissues only (check and initial all that apply):

☐ _____ All needed organs
☐ _____ All needed tissues
☐ _____ Corneas
☐ _____ Eyes
☐ _____ Other

OR

☐ _____ Only the specified organs/tissues as listed:

_____
_____
_____

Organs that can be donated: heart, lungs, liver, pancreas, kidneys, and small bowel.

Tissues that can currently be donated: skin (outermost layer from lower trunk and abdomen), bone, heart valves, leg veins, pericardium, vertebral bodies.

Eye donation can be the corneas (outer most layer), the sclera (shell), or the entire eye.

In the absence of my ability to give directions regarding the use of life-prolonging treatment and artificially provided nutrition and hydration, it is my intention that this directive shall be honored by my attending physician, my family, and any surrogate designated pursuant to this directive as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of the refusal.

If I have been diagnosed as pregnant and that diagnosis is known to my attending physician, this directive shall have no force or effect during the course of my pregnancy.

I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

Signed this _____ day of _____, 20____

_____
(signature and address of the grantor)

Have two adults witness your signature OR have signature notarized.*

In our joint presence, the grantor, who is of sound mind and eighteen (18) years of age, or older, voluntarily dated and signed this writing or directed it to be dated and signed for the grantor.

_____
(signature and address of witness)

_____
(signature and address of witness)

OR

COMMONWEALTH OF KENTUCKY, _____ County

Before me, the undersigned authority, came the grantor who is of sound mind and eighteen (18) years of age or older, and acknowledged that he/she voluntarily dated and signed this writing or directed it to be signed and dated as above.

Done this _____ day of _____, 20____

_____ _____
Signature of Notary Public Date commission expires

** None of the following shall be a witness to or serve as a notary public or other person authorized to administer oaths in regard to any advance directive made under this section:*

a) A blood relative of the grantor;
b) A beneficiary of the grantor under descent and distribution statutes of the Commonwealth;
c) An employee of a health care facility in which the grantor is a patient, unless the employee serves as a notary public;
d) An attending physician of the grantor; or
e) Any person directly financially responsible for the grantor's health care.

NOTICE: Execution of this document restricts withholding and withdrawing of some medical procedures. Consult Kentucky Revised Statutes or your attorney.

A person designated as a surrogate pursuant to an advance directive may resign at any time by giving written notice to the grantor; to the immediate successor surrogate, if any; to the attending physician; and to any health care facility which is then waiting for the surrogate to make a health care decision.

(Commonwealth of Kentucky Office of the Attorney General, n.d.)

Advance Directives

WHAT YOU NEED TO KNOW:

What are advance directives? Advance directives are legal documents that state your wishes and plans for medical care. These plans are made ahead of time in case you lose your ability to make decisions for yourself. Advance directives can apply to any medical decision, such as the treatments you want, and if you want to donate organs.

What are the types of advance directives? There are many types of advance directives, and each state has rules about how to use them. You may choose a combination of any of the following:

- **Living will:** This is a written record of the treatment you want. You can also choose which treatments you do not want, which to limit, and which to stop at a certain time. This includes surgery, medicine, IV fluid, and tube feedings.
- **Durable power of attorney for healthcare (DPAHC):** This is a written record that states who you want to make healthcare choices for you when you are unable to make them for yourself. This person, called a proxy, is usually a family member or a friend. You may choose more than 1 proxy.
- **Do not resuscitate (DNR) order:** A DNR order is used in case your heart stops beating or you stop breathing. It is a request not to have certain forms of treatment, such as CPR. A DNR order may be included in other types of advance directives.
- **Medical directive:** This covers the care that you want if you are in a coma, near death, or unable to make decisions for yourself. You can list the treatments you want for each condition. Treatment may include pain medicine, surgery, blood transfusions, dialysis, IV or tube feedings, and a ventilator (breathing machine).
- **Values history:** This document has questions about your views, beliefs, and how you feel and think about life. This information can help others choose the care that you would choose.

Why are advance directives important? An advance directive helps you control your care. Although spoken wishes may be used, it is better to have your wishes written down. Spoken wishes can be misunderstood, or not followed. Treatments may be given even if you do not want them. An advance directive may make it easier for your family to make difficult choices about your care.

How do I decide what to put in my advance directives?

- **Make informed decisions:** Make sure you fully understand treatments or care you may receive. Think about the benefits and problems your decisions could cause for you or your family. Talk to healthcare providers if you have concerns or questions before you write down your wishes. You may also want to talk with your religious or spiritual advisor, or a social worker. Check your state laws to make sure that what you put in your advance directive is legal.
- **Sign all forms:** Sign and date your advance directive when you have finished. You may also need 2 witnesses to sign the forms. Witnesses cannot be your doctor or his staff, your spouse, heirs or beneficiaries, people you owe money to, or your chosen proxy. Talk to your family, proxy, and healthcare providers about your advance directive. Give each person a copy, and keep one for yourself in a place you can get to easily. Do not keep it hidden or locked away.
- **Review and revise your plans:** You can revise your advance directive at any time, as long as you are able to make decisions. Review your plan every year, and when there are changes in your life, or your health. When you make changes, let your family, proxy, and healthcare providers know. Give each a new copy.

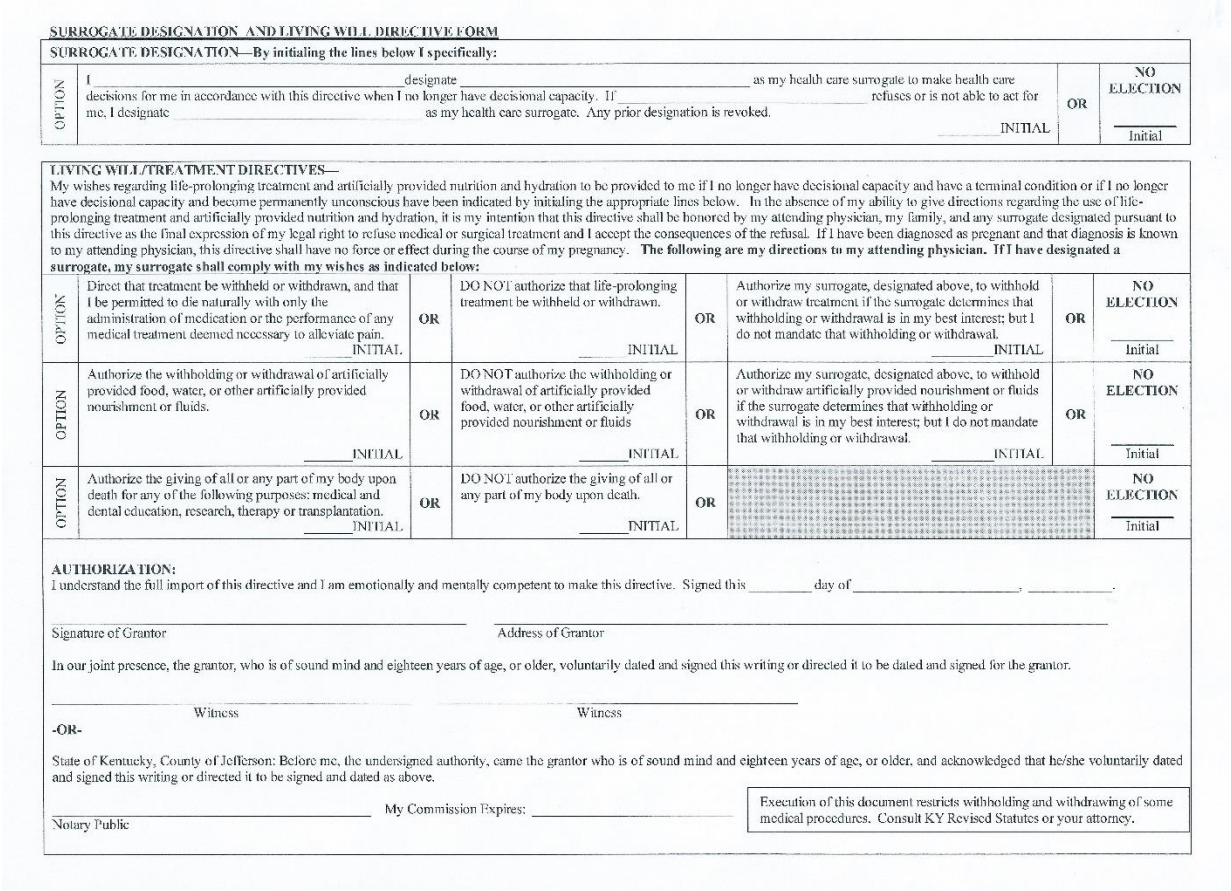
Where can I find more information?

- American Academy of Family Physicians
  11400 Tomahawk Creek Parkway
  Leawood,KS 66211-2680
  Phone: 1-913-906-6000
  Phone: 1-800-274-2237
  Web Address: http://www.aafp.org
- National Hospice & Palliative Care Organization (NHPCO)
  1731 King Street, Suite 100
  Alexandria,VA22314
  Phone: 1-800-658-8898
  Web Address: https://www.nhpco.org/

CARE AGREEMENT:

You have the right to help plan your care. To help with this plan, you must learn about your health condition and treatment options. You must also learn about advance directives and how they are used. Work with your healthcare providers to decide what care will be used to treat you. You always have the right to refuse treatment.

(CareNotes, 2019)



SURROGATE DESIGNATION AND LIVING WILL DIRECTIVE FORM

SURROGATE DESIGNATION—By initialing the lines below I specifically:

OPTION	I _____ designate _____ as my health care surrogate to make health care decisions for me in accordance with this directive when I no longer have decisional capacity. If _____ refuses or is not able to act for me, I designate _____ as my health care surrogate. Any prior designation is revoked. _____ INITIAL	OR	NO ELECTION _____ Initial

LIVING WILL/TREATMENT DIRECTIVES—

My wishes regarding life-prolonging treatment and artificially provided nutrition and hydration to be provided to me if I no longer have decisional capacity and have a terminal condition or if I no longer have decisional capacity and become permanently unconscious have been indicated by initialing the appropriate lines below. In the absence of my ability to give directions regarding the use of life-prolonging treatment and artificially provided nutrition and hydration, it is my intention that this directive shall be honored by my attending physician, my family, and any surrogate designated pursuant to this directive as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of the refusal. If I have been diagnosed as pregnant and that diagnosis is known to my attending physician, this directive shall have no force or effect during the course of my pregnancy. **The following are my directions to my attending physician. If I have designated a surrogate, my surrogate shall comply with my wishes as indicated below:**

OPTION	Direct that treatment be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical treatment deemed necessary to alleviate pain. _____ INITIAL	OR	DO NOT authorize that life-prolonging treatment be withheld or withdrawn. _____ INITIAL	OR	Authorize my surrogate, designated above, to withhold or withdraw treatment if the surrogate determines that withholding or withdrawal is in my best interest; but I do not mandate that withholding or withdrawal. _____ INITIAL	OR	NO ELECTION _____ Initial
OPTION	Authorize the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids. _____ INITIAL	OR	DO NOT authorize the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids _____ INITIAL	OR	Authorize my surrogate, designated above, to withhold or withdraw artificially provided nourishment or fluids if the surrogate determines that withholding or withdrawal is in my best interest; but I do not mandate that withholding or withdrawal. _____ INITIAL	OR	NO ELECTION _____ Initial
OPTION	Authorize the giving of all or any part of my body upon death for any of the following purposes: medical and dental education, research, therapy or transplantation. _____ INITIAL	OR	DO NOT authorize the giving of all or any part of my body upon death. _____ INITIAL	OR			NO ELECTION _____ Initial

AUTHORIZATION:

I understand the full import of this directive and I am emotionally and mentally competent to make this directive. Signed this _____ day of _____, _____.

_____ Signature of Grantor

_____ Address of Grantor

In our joint presence, the grantor, who is of sound mind and eighteen years of age, or older, voluntarily dated and signed this writing or directed it to be dated and signed for the grantor.

_____ Witness

_____ Witness

-OR-

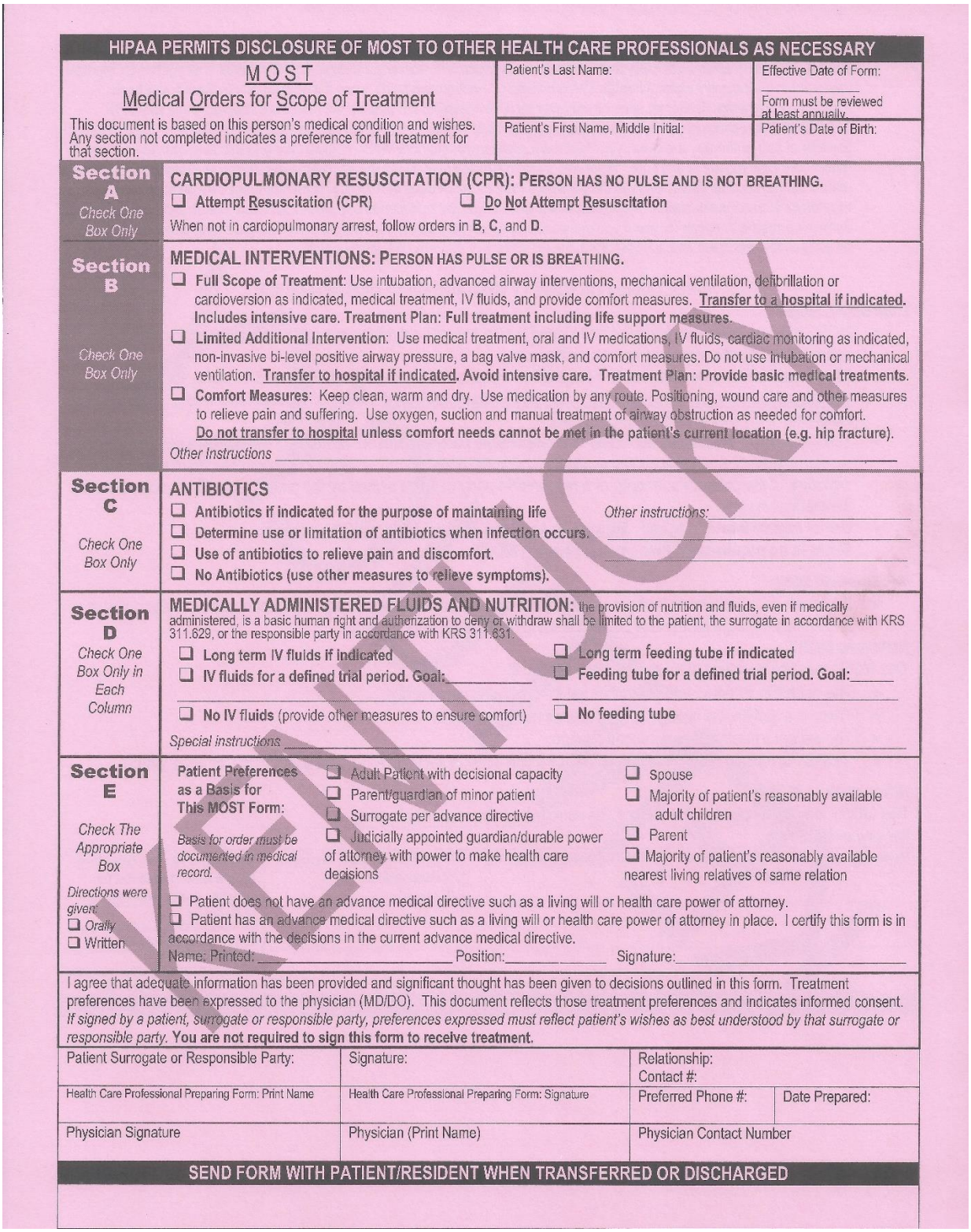
State of Kentucky, County of Jefferson: Before me, the undersigned authority, came the grantor who is of sound mind and eighteen years of age, or older, and acknowledged that he/she voluntarily dated and signed this writing or directed it to be signed and dated as above.

_____ Notary Public

My Commission Expires: _____

Execution of this document restricts withholding and withdrawing of some medical procedures. Consult KY Revised Statutes or your attorney.

("Directive Form," n.d.)



HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

MOST
Medical Orders for Scope of Treatment

This document is based on this person's medical condition and wishes. Any section not completed indicates a preference for full treatment for that section.

Patient's Last Name: | Effective Date of Form: _____ Form must be reviewed at least annually.

Patient's First Name, Middle Initial: | Patient's Date of Birth:

Section A *Check One Box Only*

CARDIOPULMONARY RESUSCITATION (CPR): PERSON HAS NO PULSE AND IS NOT BREATHING.

❑ **Attempt Resuscitation (CPR)** ❑ **Do Not Attempt Resuscitation**

When not in cardiopulmonary arrest, follow orders in **B**, **C**, and **D**.

Section B *Check One Box Only*

MEDICAL INTERVENTIONS: PERSON HAS PULSE OR IS BREATHING.

❑ **Full Scope of Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, defibrillation or cardioversion as indicated, medical treatment, IV fluids, and provide comfort measures. **Transfer to a hospital if indicated. Includes intensive care. Treatment Plan: Full treatment including life support measures.**

❑ **Limited Additional Intervention:** Use medical treatment, oral and IV medications, IV fluids, cardiac monitoring as indicated, non-invasive bi-level positive airway pressure, a bag valve mask, and comfort measures. Do not use intubation or mechanical ventilation. **Transfer to hospital if indicated. Avoid intensive care. Treatment Plan: Provide basic medical treatments.**

❑ **Comfort Measures:** Keep clean, warm and dry. Use medication by any route. Positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in the patient's current location (e.g. hip fracture).**

Other Instructions _____

Section C *Check One Box Only*

ANTIBIOTICS

❑ **Antibiotics if indicated for the purpose of maintaining life**
❑ **Determine use or limitation of antibiotics when infection occurs.**
❑ **Use of antibiotics to relieve pain and discomfort.**
❑ **No Antibiotics (use other measures to relieve symptoms).**

Other instructions: _____

Section D *Check One Box Only in Each Column*

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: the provision of nutrition and fluids, even if medically administered, is a basic human right and authorization to deny or withdraw shall be limited to the patient, the surrogate in accordance with KRS 311.629, or the responsible party in accordance with KRS 311.631.

❑ **Long term IV fluids if indicated**	❑ **Long term feeding tube if indicated**
❑ **IV fluids for a defined trial period. Goal:** _____	❑ **Feeding tube for a defined trial period. Goal:** _____
❑ **No IV fluids** (provide other measures to ensure comfort)	❑ **No feeding tube**

Special instructions _____

Section E *Check The Appropriate Box*

Directions were given
❑ *Orally*
❑ Written

Patient Preferences as a Basis for This MOST Form:

Basis for order must be documented in medical record.

❑ Adult Patient with decisional capacity
❑ Parent/guardian of minor patient
❑ Surrogate per advance directive
❑ Judicially appointed guardian/durable power of attorney with power to make health care decisions
❑ Spouse
❑ Majority of patient's reasonably available adult children
❑ Parent
❑ Majority of patient's reasonably available nearest living relatives of same relation

❑ Patient does not have an advance medical directive such as a living will or health care power of attorney.
❑ Patient has an advance medical directive such as a living will or health care power of attorney in place. I certify this form is in accordance with the decisions in the current advance medical directive.

Name: Printed: _____ Position: _____ Signature: _____

I agree that adequate information has been provided and significant thought has been given to decisions outlined in this form. Treatment preferences have been expressed to the physician (MD/DO). This document reflects those treatment preferences and indicates informed consent. *If signed by a patient, surrogate or responsible party, preferences expressed must reflect patient's wishes as best understood by that surrogate or responsible party.* **You are not required to sign this form to receive treatment.**

Patient Surrogate or Responsible Party:	Signature:	Relationship: Contact #:	
Health Care Professional Preparing Form: Print Name	Health Care Professional Preparing Form: Signature	Preferred Phone #:	Date Prepared:
Physician Signature	Physician (Print Name)	Physician Contact Number	

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

INFORMATION FOR PATIENT, SURROGATE OR RESPONSIBLE PARTY OF PATIENT NAMED ON THIS FORM

- The MOST form is always voluntary and is usually for persons with advanced illness. MOST records your wishes for medical treatment in your current state of health. The provision of nutrition and fluids, even if medically administered, is a basic human right and authorization to deny or withdraw shall be limited to the patient, the surrogate in accordance with KRS 311.629, or the responsible party in accordance with KRS 311.631. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. An advance directive, such as the Kentucky Health Care Power of Attorney, is recommended for all capable adults, regardless of their health status. An advance directive allows you to document in detail your future health care instructions or name a surrogate to speak for you if you are unable to speak for yourself, or both. If there are conflicting directions between an enforceable living will and a MOST form, the provisions of the living will shall prevail.

DIRECTIONS FOR COMPLETING AND IMPLEMENTING FORM

COMPLETING MOST

- MOST must be reviewed, prepared and signed by the patient's physician in personal communication with the patient, the patient's surrogate or responsible party.
- MOST must be reviewed and contain the original signature of the patient's physician to be valid. **Be sure to document the basis in the progress notes of the medical record**. Mode of communication (e.g., in person, by telephone, etc.) should also be documented.
- The signature of the patient, surrogate or a responsible party is required; however, if the patient's surrogate or a responsible party is not reasonably available to sign the original form, a copy of the completed form with the signature of the patient's surrogate or a responsible party must be signed by the patient's physician and placed in the medical record.
- Use of original form is required. **Be sure to send the original form with the patient**.
- **There is no requirement that a patient have a MOST.**

IMPLEMENTING MOST

- If a health care provider or facility cannot comply with the orders due to policy or personal ethics, the provider or facility must arrange for transfer of the patient to another provider or facility.

REVIEWING MOST

This MOST must be reviewed at least annually or earlier if:

- The patient is admitted and/or discharged from a health care facility;
- There is a substantial change in the patient's health status; or
- The patient's treatment preferences change.
- If MOST is revised or becomes invalid, draw a line through sections A – E and write "VOID" in large letters.

REVOCATION OF MOST

This MOST may be revoked by the patient, the surrogate or the responsible party.

Review of MOST

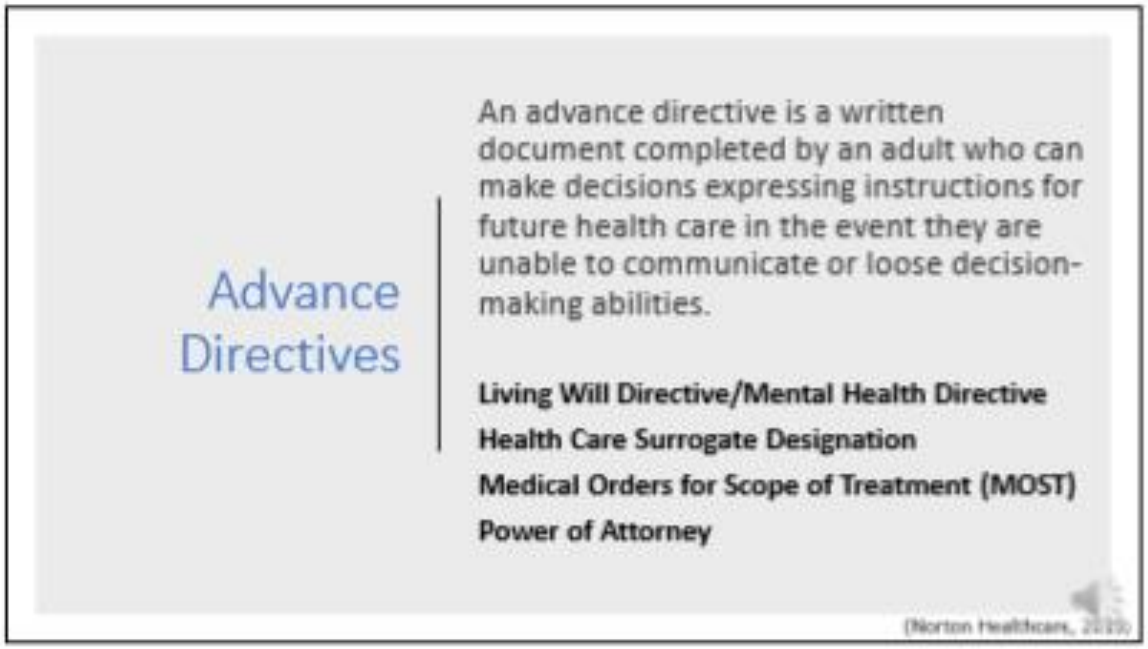
Review Date	Reviewer and Location of Review	MD/DO Signature (Required)	Signature of Patient, Surrogate or Responsible Party (Required)	Outcome of Review, describing the outcome in each row by selecting one of the following:
				❑ No Change ❑ FORM VOIDED, new form completed ❑ FORM VOIDED, **no** new form
				❑ No Change ❑ FORM VOIDED, new form completed ❑ FORM VOIDED, **no** new form

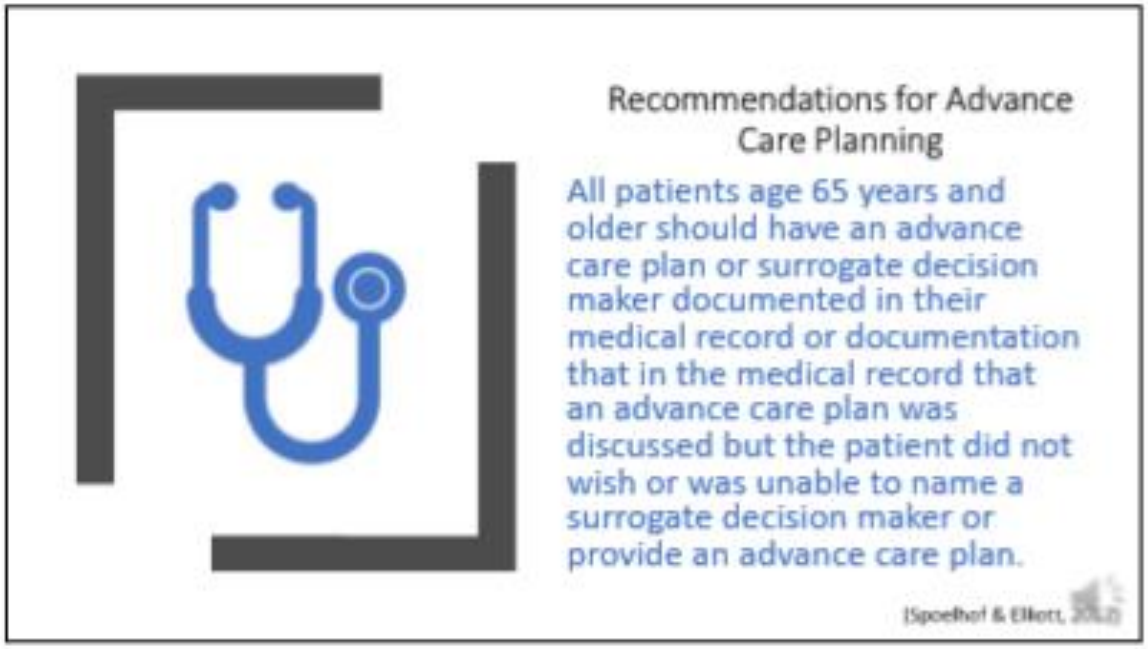
SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

("MOST Form," n.d.)

Appendix D

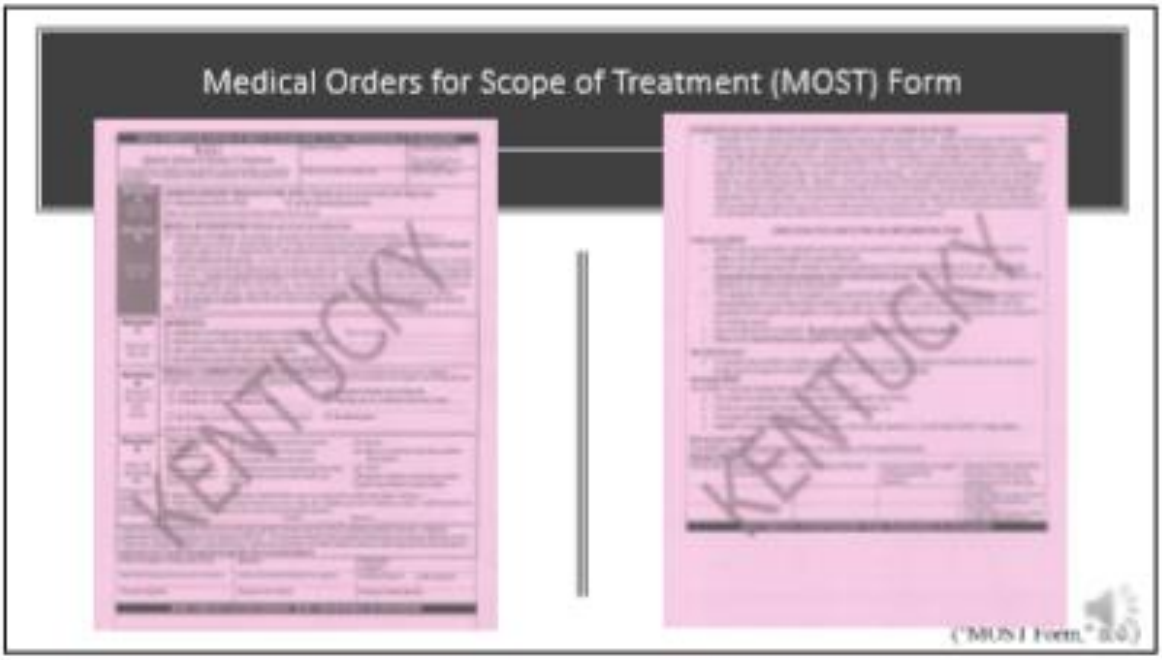
Presentation – Advance Directives for Older Adults in Primary Care

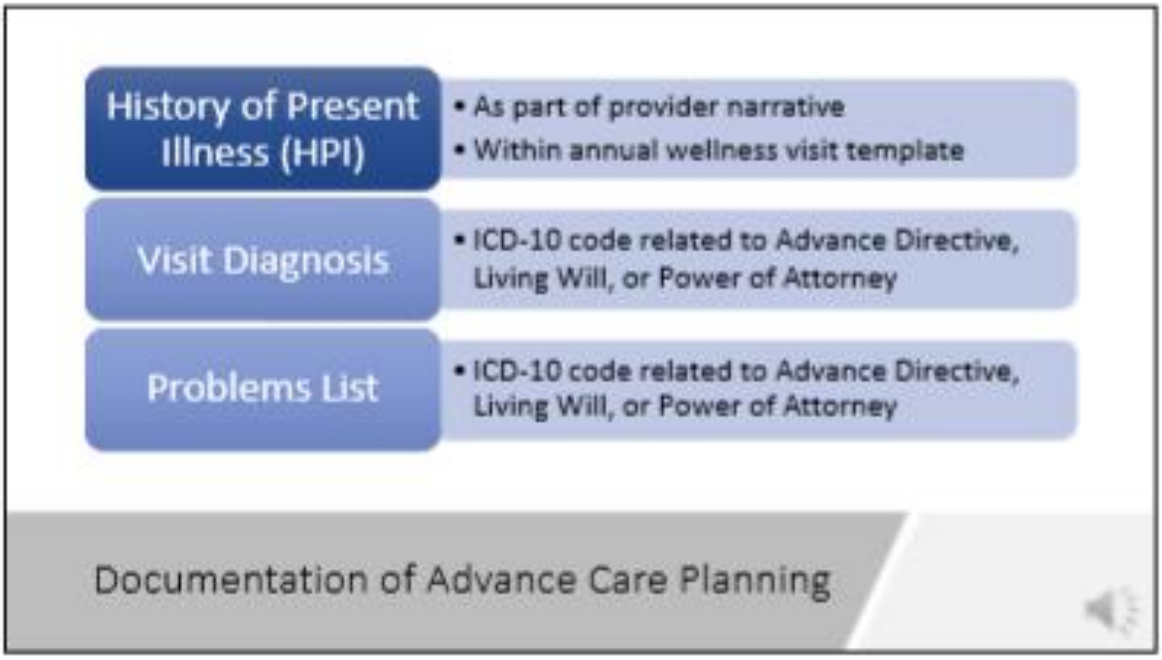

Advance Directives
An advance directive is a written document completed by an adult who can make decisions expressing instructions for future health care in the event they are unable to communicate or loose decision-making abilities.
Living Will Directive/Mental Health Directive
Health Care Surrogate Designation
Medical Orders for Scope of Treatment (MOST)
Power of Attorney
(Norton Healthcare,


Recommendations for Advance Care Planning
All patients age 65 years and older should have an advance care plan or surrogate decision maker documented in their medical record or documentation that in the medical record that an advance care plan was discussed but the patient did not wish or was unable to name a surrogate decision maker or provide an advance care plan.
(Spoelhof & Elliott,


Advance Care Planning Forms
Surrogate Designation and Living Will Directive Form
Medical Orders for Scope of Treatment (MOST) Form
("Directive Form," n.d.;" MOST Form," n.d.)


Surrogate Designation and Living Will Directive Form
("Directive Form," n.d.)


Medical Orders for Scope of Treatment (MOST) Form
KENTUCKY
KENTUCKY


History of Present Illness (HPI)
• As part of provider narrative
• Within annual wellness visit template
Visit Diagnosis
• ICD-10 code related to Advance Directive, Living Will, or Power of Attorney
Problems List
• ICD-10 code related to Advance Directive, Living Will, or Power of Attorney
Documentation of Advance Care Planning

Patient Resources for Advance Care Planning

Advance Directives: You have the right for your wishes to be followed

(Norton Pamphlet)

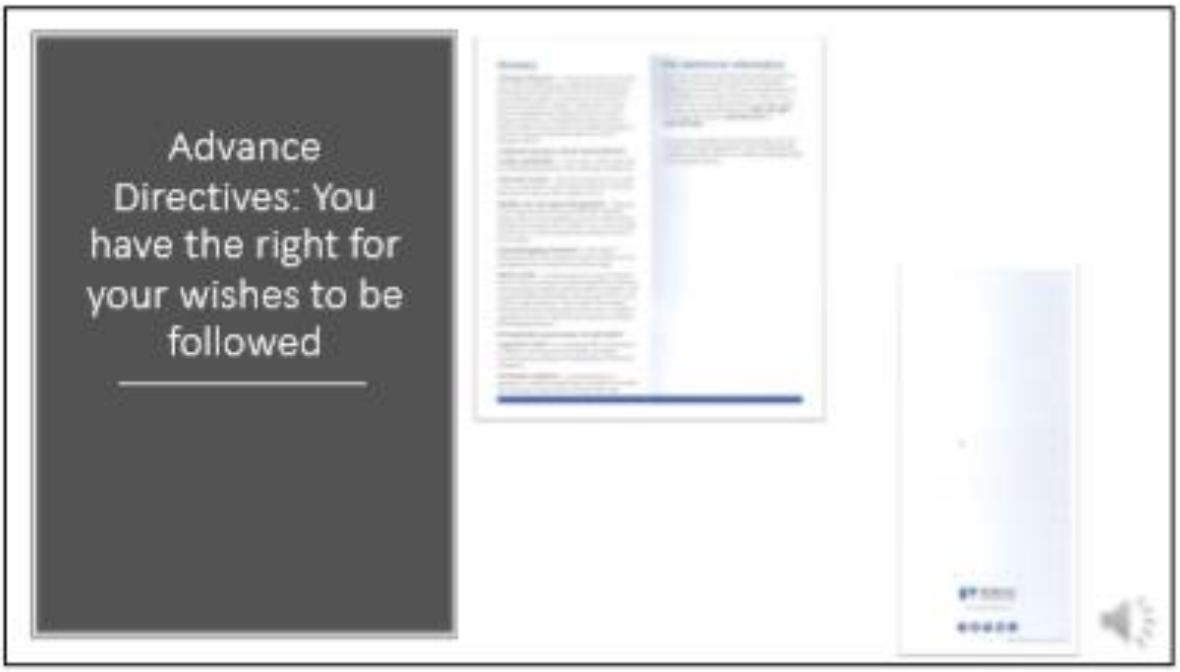
Advance Directives *(CareNotes)*

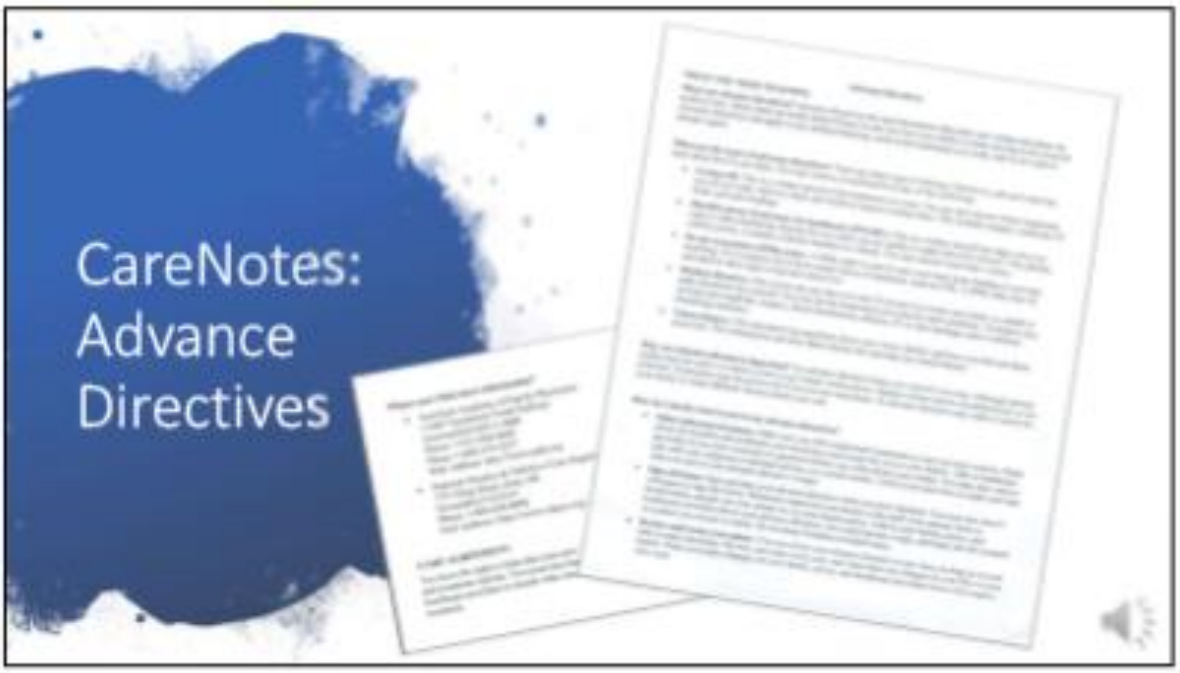
(CareNotes, 2019; Norton Healthcare, 2019)

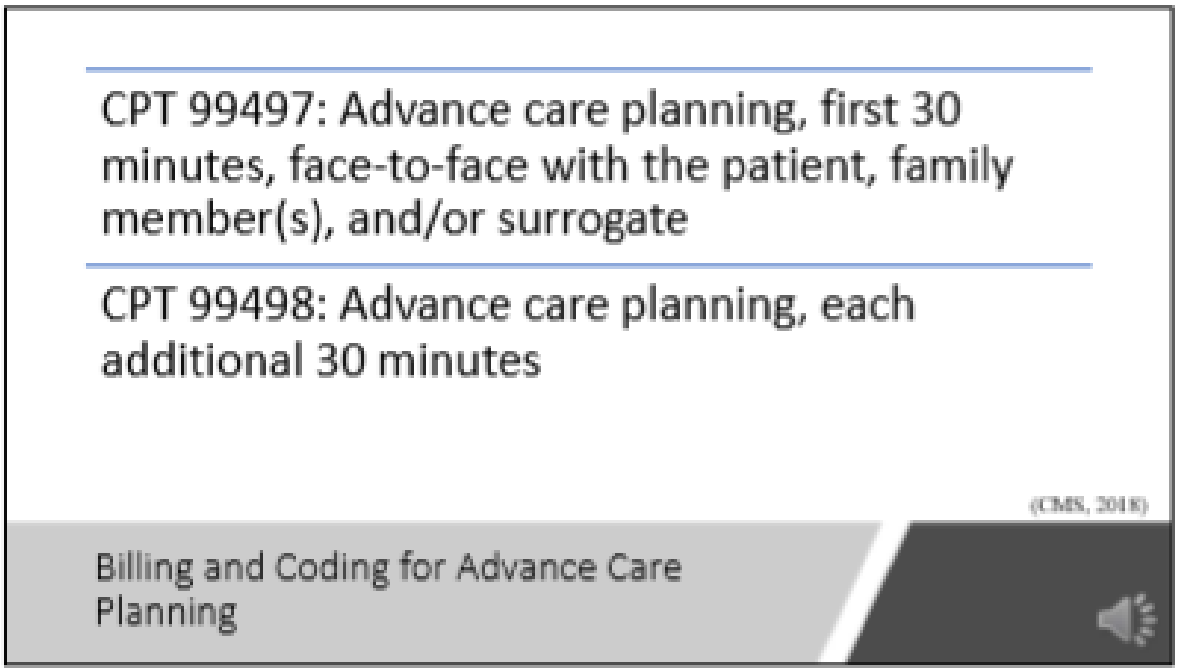
Advance Directives: You have the right for your wishes to be followed

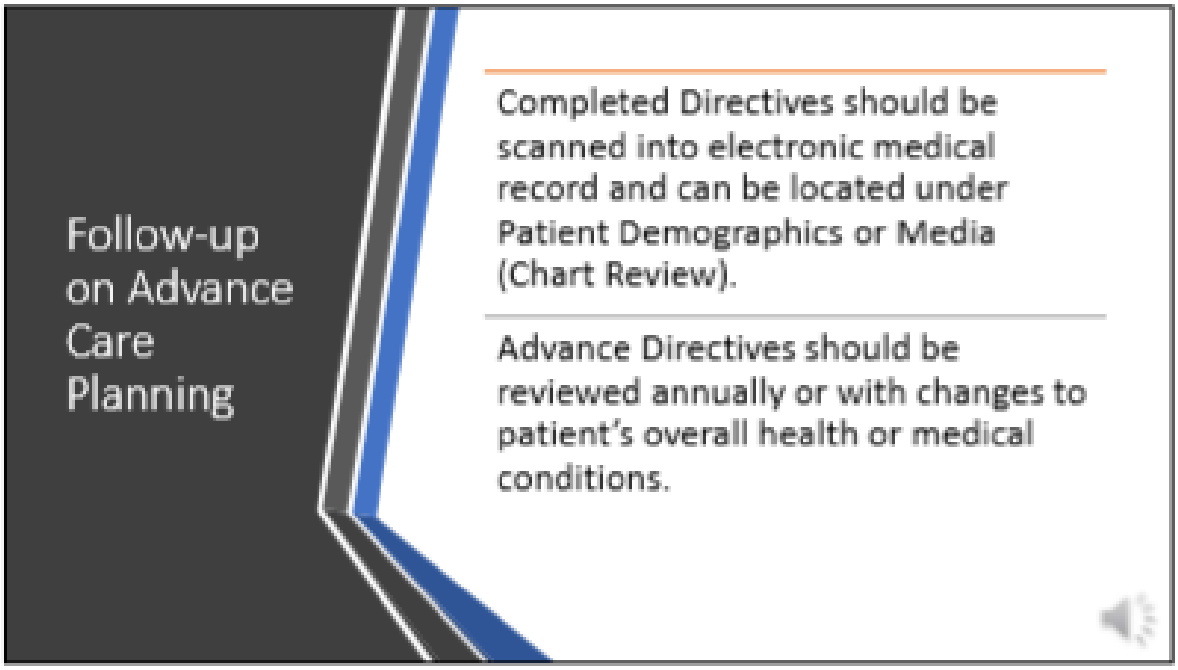

Advance Directives: You have the right for your wishes to be followed


Advance Directives: You have the right for your wishes to be followed


Advance Directives: You have the right for your wishes to be followed


CareNotes: Advance Directives


CPT 99497: Advance care planning, first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
CPT 99498: Advance care planning, each additional 30 minutes
(CMS, 2018)
Billing and Coding for Advance Care Planning


Follow-up on Advance Care Planning
Completed Directives should be scanned into electronic medical record and can be located under Patient Demographics or Media (Chart Review).
Advance Directives should be reviewed annually or with changes to patient's overall health or medical conditions.

References

CareNotes. (2019). Advance Directives. CareNotes. Retrieved from https://www.mchsmedexsolutions.com/carenotes

Centers for Medicare & Medicaid Services. (2018). MLN Fact Sheet: Advance Care Planning. Retrieved from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

Commonwealth of Kentucky Office of the Attorney General. (n.d.). *Kentucky living will packet*. Retrieved from https://ag.ky.gov/publications/AG%20Publications/livingwillpacket.pdf

Medical Orders for Scope of Treatment (MOST) - Kentucky. (n.d.). Retrieved from https://kbml.ky.gov/board/Documents/MOST%20form.pdf

Norton Healthcare. (2019). *Advance directives: You have the right for your wishes to be followed* [Pamphlet]. Louisville, KY: Author.

Spoelhof, G. D., & Elliott, B. (2012, March 1). Implementing advanced directives into office practice. *American Family Physician, 85*(5), 461-466. Retrieved from https://www.aafp.org/afp/2012/0301/p461.pdf

Sudore, R. L., Lum, H. D., You, J. J., Hanson, L. C., Meier, D. E., Pantilat, S. Z., ... Heyland, D. K. (2017, May). Defining advance care planning for adults: A consensus definition from a multidisciplinary Delphi panel. *Journal of Pain and Symptom Management, 53*(5), 821-832. https://doi.org/https://doi.org/10.1016/j.jpainsymman.2016.12.331

Surrogate designation and living will directive form. (n.d.). Retrieved from https://nortonhealthcare.com/wp-content/uploads/living-will-directive-form.pdf

U.S. Department of Health and Human Services. (2019). Physician Fee Schedule Search. Retrieved from https://www.cms.gov/apps/physician-fee-schedule/overview.aspx] [\\]

Appendix E

Advance Care Planning – Evaluation and Knowledge Survey

Demographics

Q1 Name_____

Evaluation

Q2 The education was presented in a manner that is appropriate for the content.

- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

Q3 I will use knowledge gained from this educational intervention in my practice.

- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

Q4 This educational intervention improved my confidence in advance care planning.

- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

Knowledge

Q5 Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding their future

medical care with the goal of ensuring that people receive medical care that is consistent with their values, goals and preferences.

- True
- False

Q6 Which primary care patients should be screened for an advance directive and/or health care surrogate? (Select all that apply)

- Everyone
- No one
- Patients age 65 years and older
- New patients
- Patients with new chronic diagnosis
- Patients with new terminal diagnosis
- I don't know

Q7 _____ are types of advance directives (Select al that apply)

- Living will
- Medical orders for life sustaining treatment (MOLST)
- Do Not Resuscitate (DNR)
- Organ Donation
- Durable Power of Attorney
- Oral statements
- Health Care Surrogate

Q8 Who should be screened for an advance directive? (Select all that apply)

- No one
- Everyone
- Patients age 65 years and older
- Patients with serious medical conditions
- Patients who are dying
- New patients

Q9 Where can screening for advance directive be documented in the electronic medical record? (Select all that apply)

- Screening should not be documented
- Patient Demographics
- History of Present Illness

- Problems List
- Visit Diagnosis
- Physical Exam
- Review of Systems

Q10 Where should advance directives be documented in the electronic medical record? (Select all that apply)

- Patient Demographics
- Media Tab
- Provider Note
- Paper copy in providers file cabinet
- All of the Above

Table 1. Patient Demographics

	Pre-Intervention Mean (SD) or n (%)	Post-Intervention Mean (SD) or n (%)	p-value
Age	74.1 (7.8)	73.01 (6.9)	.30 – not significant at p<.05
Sex			
Male	77 (50.0%)	38 (53.5%)	.62 – not significant at p<.05
Female	77 (50.0%)	33 (46.5%)	
Race			
Asian	2 (1.3%)	3 (4.2%)	.26 – not significant at p<.05
Black or African American	16 (10.4%)	3 (4.2%)	
Hispanic or Latino	5 (3.2%)	1 (1.4%)	
Other	1 (0.6%)	0 (0.0%)	
White or Caucasian	130 (84.4%)	64 (90.1%)	
Payor			
Medicare	137 (93.8%)	66 (93.0%)	.81 - – not significant at p<.05
Private Insurance	9 (6.2%)	5 (7.0%)	
Provider			
A	24 (15.6%)	16 (22.5%)	.44 – not significant at p<.05
B	18 (11.7%)	11 (15.5%)	
D	26 (16.9%)	11 (15.5%)	
E	86 (55.8%)	33 (46.5%)	

Table 2. Screening and Documentation

	Pre-Intervention n (%)	Post-Intervention n (%)	P-value
Screening (All Providers)			.41 – not significant at p<.05
Yes	123 (79.9%)	60 (84.5%)	
No	31 (20.1%)	11 (15.5%)	
Documentation (All Providers)			.56 – not significant at p<.05
Yes	6 (3.9%)	4 (5.6%)	
No	148 (96.1%)	67 (94.4%)	
Screening (Participating Providers)			.84 – not significant at p<.05
Yes	32(76.2%)	20 (74.1%)	
No	10 (23.8%)	7 (25.9 %)	
Documentation (Participating Providers)			.33 – not significant at p<.05
Yes	1 (2.4%)	1 (3.7%)	
No	41 (97.6%)	26 (96.3%)	

Table 3. Affirmative Screening Responses

	Pre-Intervention (%)	**Documented**	**Post-Intervention (%)**	**Documented**	**P-value**
Patient does not wish to discuss Advanced Directives	49 (39.8%)	2	18 (30.0 %)	3	.23 – not significant at p<.05
Patient needs Advanced Directive / Medical Power of Attorney; sample forms will be supplied to the patient	21 (17.1%)	2	16 (26.7%)	0	
Patient will bring a copy of Advance Directive to be scanned into medical record	46 (37.4%)	1	23 (38.3%)	1	
Patient has Advanced Directive, which is scanned into medical record	6 (4.9%)	1	1 (1.7%)	0	
Other	1 (0.8%)	0	2 (3.3%)	0	

Figure 1. Provider Attitudes

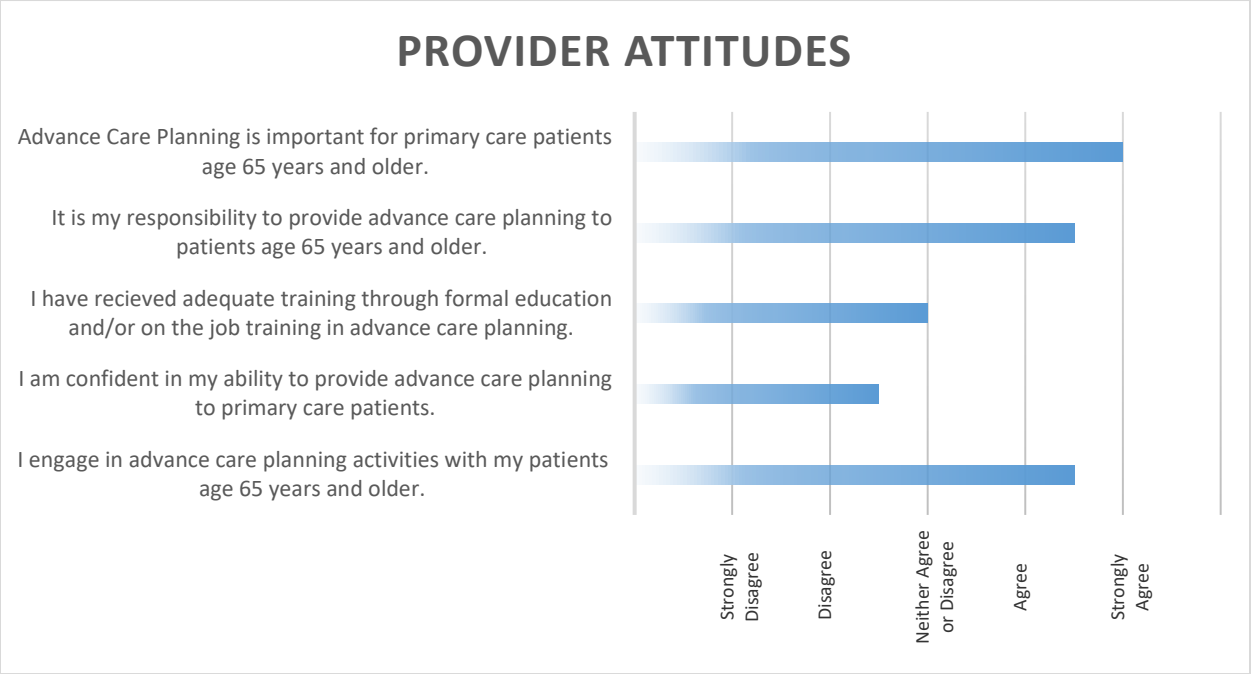


Table 4. Facilitators and Barriers

Facilitators of Advance Care Planning	**n (%)**	**Barriers to Advance Care Planning**	**n (%)**
Patient initiation	1 (50.0%)	Lack of comfort	2 (100.0%)
Resource availability	1 (50.0%)	Inadequate time	2 (100.0%)
Inclusion in work flow	2 (100.0%)	Availability of resources	2 (100.0%)
Organization support	1 (50.0%)	Patient not interested	1 (50.0%)

Figure 2. Provider Evaluation of Educational Intervention

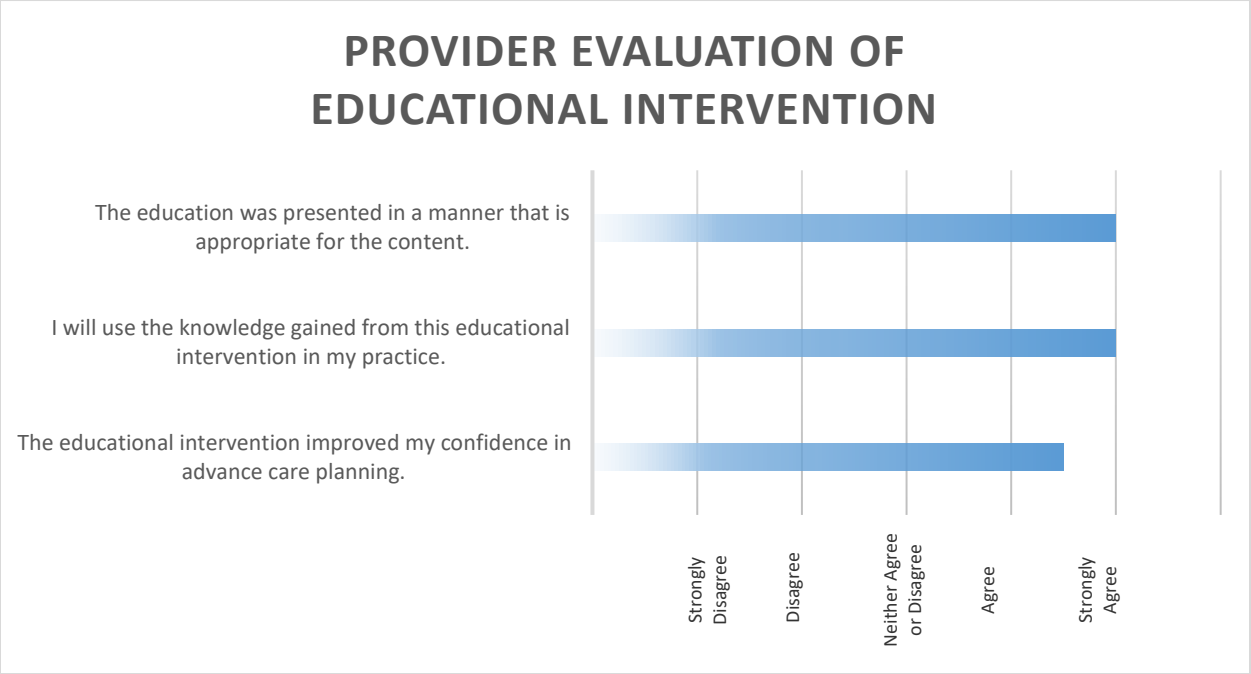


Table 5. Provider Knowledge

	Pre-Intervention Mean (SD)	**Post-Intervention Mean (SD)**	**p-value**
Knowledge Survey Score	70.5 (5.4)	83.8 (15.6)	.31 – not significant at p<.05